CHAPTER ONE

INTRODUCTION TO THE PROBLEM

Introduction

Healing after physical injury or illness is a complex experience. Whatever the trauma, a car accident, surgery, exacerbation of chronic arthritis, or a cut finger, there is more involved in the healing process than automatic mobilization of some internal chemicals to affect repair. The cut finger may include momentary surprise, perhaps followed by some personal castigation about how one could be so foolish, which may affect the healing process in some way. Surgery may have been preceded by months of worry related to pain, anaesthesia, and outcome. This time before surgery may be relevant to healing. The person with arthritis could have several remissions and exacerbations, each one changing perceptions and adding new dimensions to the complicated emotional factors, which in turn relate to the long struggle to regain strength, and perhaps gain a little time with less pain.

Most individuals have experienced differences at various times in their lives in their ability to heal after contracting a cold. Granted, the viruses vary, but there seems to be more involved than can be explained by viral characteristics or personal physical resilience.

Chemical connections are being discovered between the immune system and the emotion system (Levy, 1998). Holistic healing is an attempt to study human illnesses as

complex processes involving more than distinct cause-and-effect relationships. Many medical scientists are taking new look at how one becomes ill, how one becomes well, and what wellness means (Smith, 1996; Pender, 1996).

This researcher developed an interest in holistic healing through working as hypnotherapist and having an involvement in trying to enhance healing in both psychological and physiological ways. Some clients were observed to have rapid positive changes while others recovered very slowly. Many people with conditions such as alcoholism and premenstrual syndrome vary in their ability to recover and these variations seem to be related to differences in attitude and personality. Arthritis, allergies, and acute conditions, such as heart failure or infections, all have multiple dimensions that appeared to be relevant to healing. Recovery from conditions that were more psychological in nature, such as depression, anxiety, or reconstructing one's life after divorce seemed to have similarities to recover from physical conditions.

Healing in a broad sense was the initial topic of interest, but after reviewing the literature, the researcher recognized that more preliminary work needed to be done, because healing was undefined and much of the literature purported to be on healing was in fact on other topics such as longetivity and compliance with medical regimen. It is appropriate to examine one segment of healing and build on that with further research. Individuals in a process that could be readily identified as healing, is the appropriate population to use in exploring this phenomenon. To understand the experience of healing from the perspective of the individual in the process of healing, the following research question was asked.

Statement of the Problem

The study assumes that holistic healing has an integrative theory that guides its process. Additionally, it assumes that holistic healing adheres to a theoretical orientation that promotes universal spiritual ideals as opposed to specific religious ones. The researcher believes that human existence is multidimensional. In addition, this study assumes that illness, whether physical, psychological or spiritual affect all the levels of existence of the human body, mind, and spirit.

Background and History of the Problem

Holistic healing remains on the edges of mainstream scientific thought. It is contrary to the accepted view that we will always be able to find a specific cause for any given illness. Otto and Knight (2001) state the following:

> Holistic healing deals with the totality of a person's being: the mental/emotional, physical, social, and spiritual dimensions. It is this totality as an integrative and synthesizing force, so perceived and utilized by the healing person or team, that constitutes holistic healing. (p. 3)

Holistic healing is described by Pelletier (1997). For him, all states of health are psychosomatic, each person representing a unique interaction of body, mind, and spirit. Illness is a disturbance in the dynamic balance of these relationships. The client and the practitioner share the responsibility for the healing and both creatively learn about themselves during the healing process.

Purpose of the Study

In spite of a thorough search of the literature, no studies have been found that relate directly to the focus to this study, the experience of holistic healing. The holistic healing perspective in this study implies that healing is much more than physiological change.

The literature review is not the theoretical foundation on which the study is based, but it is represented in order to illustrate the current state of the relevant literature. The initial review established the appropriateness of this study. The majority of the review will be accomplished after the data is analyzed and will be guided by the findings. Literature from both the initial review and the later review will be combined and the connections between the literature and the results of this study will be explored in the later chapters.

Topics will also be discussed that might relate to the experience of healing, such as health status, recovery, and survival. In this related literature the independent variables such as social support, optimism, and hardiness are often well defined with reliable and valid measures. The dependent variables such as "being healthy, having minor health problems, suffering from chronic disease, being disabled, and being dead are treated as equally-spaced points on a continuum" (Hobroyd & Coyne, 1987, p. 364), and are not often well-defined or measured. Other measures sometimes defined as "healthy" are help seeking behaviours and compliance with medical recommendations.

Attempts are often made to define personality characteristics that relate to health and survival. Krantz and Hedges (1997) discuss that enthusiasm outweighs the evidence about how personality traits, psychological factors, and behaviours relate to illness.

Nevertheless, there are some interesting studies in which an attempt is made to measure the factors that might be relevant to healing. The popular literatures claim much more knowledge than can be substantiated with valid research but this literature has stimulated a research interest that will lead to more knowledge about healing.

Significance of the Study

This study seeks to add valuable information about the growing phenomenon of holistic health. It strives to explore the process of holistic healing. In the process of investigating the study's hypotheses, this study seeks to discover novel, unanticipated themes that help further the understanding of holistic healing.

Research Question:

This research investigates the main question: *What does it mean to be holistically healthy?*

Hypotheses:

So the hypothesis of this study would be: Personal experiences will be a key contributing factor to participants' experiencing a holistic healing.

Scope and Limitations

The literature indicates a growing interest in holistic health. For example, there is increasing research on healing practices (Cappannari, Rau, Abam & Buchanan, 1995) and holistic healing efficacy (Frank, 1993; Hall, 2003; Krieger, 1994). However, surprisingly few researchers investigated the practitioners of holistic healing (Moch, 1998; Voelker,

1994). Despite the growing research about holistic healing practices or that debates holistic healing concepts (Simonton & Matthews-Simonton, 1994), this study found an absence of research devoted to actual holistic healing.

Hence, in spite of a thorough search of the literature, no studies have been found that relate directly to the focus of this study, the experience of holistic healing. The literature review is not the theoretical foundation on which the study is based, but is presented in order to illustrate the current state of the relevant literature. The majority of the review will be accomplished after the data is analyzed and it will be guided by the findings.

Definition of Terms

The following are the various definitions of holistic healing which the researcher believes are imperative in understanding the research documented in this manuscript.

Holistic healing

Literally, it means wholeness (holy and heal both derive from the Anglo-Saxon *healen*, meaning whole), with all that implies: "Bringing the rejected and discarded into the circle; listening with the inward ear for those parts that have been silenced; seeking a deeper, more accurate, more creative engagement with the world around us" (Barasch, 1993, p. 57).

Holistic

This refers to the acknowledgement that human beings are multi-leveled. Human beings exist each moment as a body, mind, spirit/soul, and emotional being. Holistic healing therefore acknowledges the many parts of a human being and seeks to understand their interactions in both the imbalance and the health creation processes.

For holistic practitioners, the term "holistic" may mean the use of alternative healing techniques or procedures such as the use of herbal remedies, diet and nutrition. For psychologists "holistic" may indicate their use of several therapeutic techniques within the discipline of psychology. Or, it may indicate that they integrate other healing techniques such as bodywork or meditation within the context of psychotherapy. For some, the term "holistic healing" denotes an overall philosophy of integrationalism regardless of their respective training background, and as such, serves as a self-identifier. Given the disparity of meanings attributed to the words, the realm of holistic healing is fraught with communication difficulties. This search terms clarifies for the operational definitions of the study's critical terms to avoid confusion and help set the limits of its purview.

The research question asks about the experiences of holistic healing. The study seeks to explore the relationship of its variables to the participants' life experiences. Therefore, this study uses a qualitative phenomenological design mentioned to gather information.

Characteristically, phenomenological interviews are open-ended and unstructured. However, a purely phenomenological design does not allow for specific research variables to be explored. Therefore, this study utilized a modified phenomenological

design. The study attempts, through its methodology, to identify themes that adequately reflect participants' experiences and to understand their meaning.

The field of holistic healing is an evolving discipline. Therefore, the words used to speak about the realm of holistic healing remain difficult to concretize. For those who view this growing field from a distance, the confusion about communication is apparent. Essentially, the same words are used in different ways, depending on the speaker and on the context. Even practitioners within the field of holistic healing use words like "healing" and "holistic" in idiosyncratic ways.

Summary

In summary, this chapter identified the study's aim of achieving a more complete knowledge of the experience of holistic healing. Ultimately, understanding this human experience will assist in promoting holistic healing. The rationale for this study stems from the promotion of holistic healing, coupled with inadequate understanding and research regarding matters of people's experiences of holistic healing. Asking people for their impressions regarding their holistic healing experiences would reveal the importance of relying on the client as the most important information resource.

CHAPTER TWO

REVIEW OF RELATED LITERATURE AND RESEARCH

Introduction

In spite of a thorough search of the literature, no studies have been found that relate directly to the focus of this study, the holistic experience of healing. The literature review will present the theoretical foundation on which the study is based, but is presented in order to illustrate the current state of the relevant literature. The majority of the review was accomplished after the data were analyzed and was guided by the findings. Literature from both, the initial review and the later review have been combined in this section. Connections between the current literatures to the results of the present study will also be.

Research Literature Review

Historical Background of Holistic Healing

Although there has been increasing interest in holistic healing over the past two decades, citing a specific date in which this movement began proves difficult.

Holistic health has multi-cultural, multi-temporal origins. The current "holistic healing movement" in our Western culture revisits very ancient healing traditions.

The earliest known document advocating holistic health care concepts originated in China around 2585 B.C. The manual is known as the Yellow Emperor's Classic of Internal Medicine or the Nei Ching. The text takes the form of dialogues between the then current Emperor of China, Huang Ti and his physician Ch'i Pai (Veitch, 1949).

In essence, the Nei Ching developed a theory of humanity in health and sickness and a theory of medicine. The author accomplished this by using the philosophic concepts of the time picturing human beings as a microcosm that reflects the macrocosm of the universe. Human beings, as a reflection of the cosmos, contain the fundamental natural energies of Yin and Yang and a combination of the five basic elements: Fire, Air, Water, Wood and Metal, which symbolically exist in every organ of the body.

This text was the first to connect health to how one lived: their environment, nutrition, spiritual life and practice (in relation to the Tao, with its dual role as supreme regulator of the universe and as the highest code of conduct). Although Western medicine reached China in the early 17th century, the theory expounded in the Nei Ching remains the dominant theory of Chinese indigenous medicine to the present day (Veitch, 1949). Holistic healers today still adhere to its basic tenets.

In Greece several thousand years later, approximately 460 B.C., a shift toward holistic healing occurred. At that time, Hippocrates, acknowledged as the father of medicine, made unique observations of the human body in ill states. Hippocrates witnessed the available healing techniques and realized their limited capabilities. Hippocrates noticed that the healer/priest techniques of bloodletting, reciting incantations and making offerings to the Gods, at the best was no good and more often proved lethal to the "patient." As a result of these observations, Hippocrates developed and promoted

the idea that health and sickness were not gifts or punishment from the Gods. Instead, he explained that illnesses resulted from natural causes and that, therefore, natural remedies, foods, minerals and life style changes, could ameliorate them.

Hippocrates's medical philosophy challenged the then current cosmology of health. Causation once attributed to the spirit realms shifted to the earthly plane as he advanced the idea of natural causes and courses of health imbalance and posited that understand laws, not mysteriously ones, governed illness. Additionally, Hippocrates offered the idea that the body heals itself of sickness through corrective actions that include manifestation of symptoms: "The physis (body) is in the vast majority of cases quite competent to solve its own problems. Give the organism healthy surroundings, food, and condition of life, and it will as a rule quickly regain health of itself" (Brock, 1929, p. 12).

Hippocrates states that the physician should intervene in the illness process only at "critical" moments, when the body "reached a moment of truth in which restoration of health or death hung in the balance" (Brock, 1929, p. 10). For Hippocrates, the healing process thus consists of a triad: physician, patient, and the conditions surrounding the patient.

Current proponents of holistic health care align themselves with the teachings and medical philosophies promoted by Hippocrates. These include the belief in the naturalness of health imbalance, the advocacy for natural, non-invasive remedies, and the importance of healthy life style for the prevention of health imbalance.

The ritual of reciting the Hippocratic Oath and swearing to uphold it remains a tradition in the training of allopathic doctors. However, much of the actual practice of

allopathic medicine does not emphasize Hippocrates's original healing concepts and teachings. Western medicine has separated itself from Hippocrates's original philosophy of medicine.

A number of factors have contributed to the change in focus from early holistic concepts of healing to reductionistic underpinnings, from the ideas of natural causes and remedies to invasive foreign entities and technological medical interventions. The shift of modern medicine away from its Hippocratic roots remains for some the fundamental underlying causative factor of the advancement of a holistic health perspective (Berliner & Salmon, 1980; Gordon, 1981; Gordon, 1990; Rosch & Kearney, 1985; Schwartz, 1991).

Historically, medicine has moved away from its Hippocratic roots of holism, naturalism and humanism. The resulting situation characterized by a reductionistic attitude has involved searching for sole causes of disease and viewing individuals as "bodies," unidimensionally ignoring other aspects of their lives and beings. Rather than acknowledging the role mind plays in somatic illness, or acknowledging the effects of spiritual concerns upon the meaning an illness had for patient, physicians have focused on symptom relief above all else (Berliner & Salmon, 1980; Gordon, 1990).

The advancements of modern Western medical technology inadvertently have contributed to the advancement of a holistic model. As traditional medicine developed more advanced technology, patients and physicians became increasingly reliant upon it. As this occurred the costs for medical treatment began to soar. In 1978, medical care costs comprised nine percent of the Gross National Product or about 162.6 billion dollars, and they continue to rise. Physicians discovered that medical technology was not a

neutral force but implored its own use, resulting in exorbitant and burdensome costs to individuals and third party payers (Gordon, 1981; Rosch & Kearney, 1985). One physician even credited technological advancement with the "creation" of the holistic movement (Gordon, 1990).

With the advent of technology, such as the microscope and x-ray, and the discovery of germ theory and visible bacteria, disease and illness became a fight against foreign invaders. During this surge of technological advancements, beginning in the 1940's, illnesses could be traced to germs, and infections illnesses could be traced to a single bacteria, this led to the invention of powerful drugs that could be traced to germs, and infections illnesses could be traced to a single bacteria. This led to the invention of powerful drugs that could kill the offending agent and restore health to the organism. When a person exhibited symptoms of an illness, researchers developed a drug to alleviate the symptom, or a surgical technique to remove the diseased part, or a machine to radiate the invading microorganism.

This attitude and emphasis of medicine prevailed, until a shift occurred in the diseases people exhibited. Physicians no longer saw patient with infectious diseases, but chronic and debilitating heart disease, cancer, and immunological dysfunctions. The reductionist attitude with its search for the single causative agent proved futile against these diseases. Researchers have still have not isolated a sole cause for cancer, hypertension or many other of the disorder that afflict the population. Instead, many physicians and researchers discovered that a complexity of factors contribute to the onset of these "stress-related" disease. These factors include life style, stresses at home and work, eating habits and play habits (Borysenko, 1994; Kabat-Zinn, 1990).

Concomitant with this reliance on technology, reimbursements for medical care emphasized procedural activities over cognitive or relational ones. Physicians could get reimbursed from third party payers for activities they performed on the patient, but not for time spent building relationships with them or thinking about their concerns.

Results from this prevailing atmosphere within medicine have led to doctors feeling increasingly fragmented. Some medical doctors felt that trying to keep up with medical technology curtailed their time spent with patients (Gordon, 1990). Physicians felt themselves losing their sense of humanity through the overuse and overemphasis on medical technology and the time limits dictated by overwhelming patient loads to the advent of managed care with its emphasis on the "bottom line" (Berliner & Salmon, 1985; Gordon, 1981; Rosch & Kearney, 1985).

As more information about health care became available to the lay population through the use of computer-net information retrieval systems and popular media attention, physicians began to see a more educated patient population who wanted more control over and autonomy in their health care decision-making. Additionally, patients voiced concern over the unknown and long-term side effects of medications and the use of unnecessary surgery. The increased education served to demystify medicine and helped alter the doctor-patient relationship. Peoples' need for increased autonomy coupled with medical knowledge dovetailed with the admonition by holistic practitioners to equalize the power in the healing relationship and utilize the peoples' self-responsibility for their own health care. Together, these contributed to the health perspective developed through the contributions of technological advancements, changes in types of diseases afflicting the population, the growing dissatisfaction of physicians

themselves and the increasing education and sophistication of patients. In response to these factors, in 1978 a group of medical doctors formed an association of holistic medicine. Essentially, they called for a return to the original Hippocratic concepts of illness and health and a more holistic approach to health care. This group of physicians described themselves as "an organization interested in promoting an integrated comprehensive overview of patients as physical, mental, emotional and spiritual beings" (Relman, 1979, p. 312).

The approach they advanced provided an alternative to the predominant allopathic tradition of medical care and a challenge to the current state of healing in Western culture. A holistic approach to health requires acknowledging the complexity involved in healing. Unlike believing that there is one "cure" for a particular symptom, a holistic approach to health acknowledges that there may be many. "The human experience of disease and healing is as diverse as our fingerprints" and the holistic approach to health care acknowledges this by word and deed (Barasch, 1993, p. 45).

The basic tenets of holism acknowledge both the multilevel nature of human existence and of the healing process and seek to facilitate healing of the whole person. However, there are many theories and disciplines that may accomplish this. No two theories or disciplines address the respective level of focus, mind body or spirit in the same way. No two practitioners when trained in the same healing method or philosophy will offer the same healing approach. Furthermore, no two persons need the same healing techniques for healing to occur. Therefore, each individual must make their own choices from the available health care possibilities. A holistic approach to healing allows for both the complexities of healing and the diversity of each human being.

The Purview of Holistic Healing

The literature on holistic healing encompasses many disciplines and healing traditions. It is a vast and varied domain. It is not surprising then, that many of the healing modalities included in the holistic movement differ fundamentally in their viewpoints and philosophies of health and healing. It suffices here to acknowledge this characteristic inherent in the modalities covered under the rubric of holistic health. In addition, to outline all the possible modalities that one may include in the purview of holistic health care falls beyond the scope of this study. Rather, this paper focuses on the most predominant modalities written about in the holistic healing literature.

The modalities discussed herein intend to provide an overview of the purview of holistic health. Each modality emphasizes the various aspects and domains of being; physical, mental, emotional and spiritual differently. As a group, they advocate unique philosophies of healing modalities focused on in this paper include Allopathy, Homeopathy, Naturopathy, Chinese Medicine and Spiritual-Healing. The following sections discuss how each of the aforementioned traditions view the healing process, understand the components of health care (the roles of practitioner, client, illnesses, etc.) and define health, illness, and the healing process.

Allopathic Medicine

Allopathy, “allo” from Greek for “other” and “pathos” for “suffering disease” combine to refer to the use of modalities that can cause the opposite effect as that created by diseases. This term was introduced by Samuel Hanehmann, the father of homeopathy. Western medical school teaches this philosophy of healing and it remains the most

common form of healing currently used in traditional Western medical care. Allopathic medicine distinguishes itself from other healing modalities by its developmental roots (Brock, 1929).

The tradition of Allopathic health care, developed in tandem with important scientific discoveries, remains at the root of allopathic philosophy and approach. Modern allopathic medicine, though often traced to the time of Hippocrates, really did not emerge until early 16th century when Andreas Vesaluis, a Flemish physician, did some of the earliest anatomy experiments. Later, William Harvey's description of the circulation of the blood and functioning of the heart provided a major leap in understanding the workings of the human body. However, not until 1660, when the microscope was developed, giving us the first glimpse into the world inside our bodies (Brock, 1929).

Concurrent with these important discoveries in medical science, Rene Descartes crystallized his concepts of mechanism and dualism, creating the model of the body as machine, separate from the mind, a principle behind which much of western care orients itself. About 100 years later, Isaac Newton provided the mathematical and scientific underpinnings to these concepts which became the dominant world view of the West for the next 300 years. These concepts, both philosophical and scientific, became the foundation for the medical discoveries of the 19th century.

In 1860 Louis Pasteur discovered that microscopic organisms, viruses and bacteria, could cause illness. As a result of his important work, medical science began looking for the foreign disease-causing entities that invaded the body and produced disease. A major advance in the search was the development in 1895 of the x-ray machine and electron microscopes which awakened science to the power of technology to

provide information about disease. Science began to look to the cellular level for the answers to health questions. Pasteur's germ theory to explain the origin of illness gained overwhelming acceptance in the West during the early 20th century. Since most all sickness was thought to originate from microscopic organisms, science began to search for the means to kill these creatures. Synthetic drugs offered the most promise. Since the 1940's new drugs have been created by the thousands after antibiotics proved to heal infectious health problems, which was the major cause of mortality at the time.

Allopathic philosophy of medication promotes healing the illness by getting rid off the symptom with an agent that causes the opposite effect. For example, if a person presented with a swollen ankle, a Western doctor would commonly suggest a drug and/or medical technique that reduced swelling. Traditional allopathic physicians are trained to believe that removing symptoms alleviates the problem and usually restores health to the body.

With the exception of accidents causing broken bones or injured organs, a "microscopic invasion" characterizes the essence of how physicians view illnesses. When illness occurs within the body, a traditional doctor identifies the illness through observation and by means of sophisticated analysis and testing. Then he or she recommends drugs to kill the invading force, alleviate the symptoms and bring the body back to health. If the symptoms progress beyond the point where drugs alone will alleviate them, the doctor may recommend other techniques such as surgery or radiation.

Homeopathy

The tradition of homeopathic medicine developed with the work of Samuel Hahnemann, a disillusioned German physician in the late eighteenth century. Hahnemann abandoned conventional medical practice after years of experience persuaded him that he was nothing more than "the murderer and tormentor of my brethren" (Whorton, 1985, p. 29). Hahnemann noticed that most fatalities arose from the side effects of remedies given, for example, heavy metals and the use of mercury. When through self-administered experiments, he discovered that a dose of cinchona, the quinine-containing remedy for malaria, produced sensations similar to the symptoms of malaria, he began researching substances that produced symptoms like the condition needing healing. Based upon his observations and experimentation with various substances, he discovered the principles of homeopathy.

The definition of health and the components of health care such as symptoms and identification of imbalance have different meanings from a homeopathic orientation. The homeopathic tradition defines health as a state of freedom existing on the physical, emotional, and mental levels. It includes freedom from physiological malfunction, emotional peace, freedom of expression, mental clarity and creativity (Cummings & Ullman, 1991). Homeopathists view the person as whole and identify the problem with information about the totality of the person. He or she considers a complexity of factors such as traditional physical symptomatology, mental functioning, reactions to foods and temperature. Advocates of homeopathic practices view symptoms as the body's innate way of combating an imbalance in the system. Homeopathic practitioners design remedies to help the body to fight and support its natural healing potential.

Homoeopathists recognize that the presence of an imbalance stimulates the body's defense to eliminate the imbalance. The defensive reaction produces symptoms, which are part of the body's effort to eliminate the underlying condition. The symptoms are not the condition, but accompany the condition and, therefore, are part of the healing process.

A fundamental philosophical principle for homeopaths is called the Law of Similarity. This law states that "like heals like" (Whorton, 1985, p. 29). The essence of this Law holds that a substance which produces a certain set of symptoms in a healthy person has the power to correct an ailment manifesting those same symptoms. Western medicine utilizes this philosophy and its effects in immunizations for modern illness, where a small amount of the "disease" is injected into a person and the body responds by producing antibodies. These antibodies help the body fight the illness should exposure occur in the future.

Another basic law discovered by Hanehmann, the Law of Potentiation, stating that smaller doses are more patent against health imbalance. Therefore, when recommending, a homoeopathist would suggest for an individual a given substance in a micro dose. The minimum dose would be administered only until the body reacted. Once the healing process begins, indicated through body reaction, the practitioner would give no other remedies or further doses. Homeopathists realize that this type of healing approach supports the body's natural defense mechanism. In contrast to allopathic medical approach in which doctors strongly suggest drugs, often more than one, in large doses that have the opposite effect of a symptom, hemeopathists takes a gentle, natural healing approach. Hemeopathist's contend that when symptoms are suppressed, the

imbalance goes deeper into the body and this could lead to a more serious condition that is harder to eliminate.

Naturopathy

Benedict Lust, a German-born healer, developed this healing orientation in the early 1900s after he cured himself of tuberculosis through natural means. Naturopathy has its roots in the healing of the Greek European and Chinese traditions. This healing orientation does not align itself with any one specific unifying principle from these healing traditions, such as the concept of Yin and Yang or the five elements. Rather its basic philosophy contends that the body heals itself through utilizing the underlying life force, which is the source of all healing. Naturopaths are dedicated to restoring the ability of the person to heal him or herself. To assist this process, naturopathy promotes the use of nontoxic healing methods derived from the "best traditional healing systems around the world" (Monte, 1997, p. 19).

The naturopathic philosophy views sickness as caused by the buildup of toxins in the body. Naturopaths state that a number of factors contribute to a toxin build-up that ultimately may lead to illness. These factors relate to the whole person, their lifestyle and emotional health, physical condition balance of work and relaxation, and connection to vitalizing life force. Some of the imbalance causing factors include unhealthy diet rich in harmful ingredients such as animal fat, sugar, artificial ingredients and low in essential vitamins, minerals and fiber, improper posture and body structure, destructive emotions such as stress and hatred that have effects on internal organs and the immune system; excessive use of suppressive drugs, antibiotics, vaccinations; prolonged exposure to

harmful environmental agents in the air, water an workplace; and genetic factors that may create certain weaknesses in the human system which allow accumulated toxins and other factors to manifest as health imbalance.

From a naturopathic viewpoint, symptoms are the body's best effort at self cleansing. The body uses symptoms such as sneezing, fever, coughing and others to eliminate the underlying conditions that promote imbalance. Naturopathic healing interventions intend to assist the body in its natural process of cleansing. To achieve this, naturopathic healers use many methods such as diet alterations and fasting, colon-hydrotherapy, massage, acupuncture, herbology, chiropractic manipulations and others.

Naturopaths acknowledge modern allopathic medicine for its usefulness in crisis intervention though primarily they remain committed to using nontoxic and non invasive healing methods.

Chinese Medicine

Chinese medicine began around 2500 B.C and credited to the writing of the Yellow Emperor. Fundamental elements to this philosophy of medicine included the concept of the Tao, the interaction of the five elements the seasons and the balance of Yin and Yang: "Those who follow Tao, the Right Way, can escape old age and keep their body in perfect condition" (Veitch, 1949, p. 100).

In additions, central to Chinese healing is the belief in the principle of Yin and Yang, the basic principle of the entire universe. Both these energies are distinctive yet inseparable poles of the life energy. Together they maintain a dynamic balance neither more valuable than the other (Askster, 1986). As the fundamental elements that

constructed the universe and man according to Chinese philosophy Yin and Yang and the balance of vitalizing life energy plays an important role in Chinese medicine.

Ailment entities as we view them today did not exist in ancient Chinese medical thought. Instead, Chinese physicians viewed a number of things as causative factors to health problem; the lack of balance and disharmony of Yin and Yang or the five elements, weather conditions peculiar to each season or by infringements against the Tao. Most commonly an imbalance of Yin and Yang characterized illness. The remedy sought to restore balance by adding or distracting energy from weak organs.

In the Nei Ching, the specific section of the famous Yellow Emperor's text outlines several traditional healing components. The first, termed the "Cure of spirit," consisted of guiding one toward Tao those persons who by infringement of the basic rules of the universe had severed their own roots and ruined their true selves. Therapeutic activities included obedience, the practice of modesty and a retiring way of life, the avoidance of all excesses, and being an example to others in true devotion (Veitch, 1949). Another healing component included the five flavors: pungent, sour, sweet, bitter and salty. Each of these were thought to have dispersing gathering retarding strengthening and softening effects and were proscribed depending upon the type of imbalance identified.

However, acupuncture remains the most predominant healing modality currently used by Chinese physicians today. Although numerous references contained in the Nei Ching recommended the use of acupuncture it contained very little information concerning its method of application.

Currently, Chinese doctors and acupuncturists utilize the system of meridians in the body. Meridians or energy pathways transport energies that correspond to the body's organs and to one's emotional/psychological states. Like a superhighway structure the meridians are composed of large central pathways and smaller peripheral ones. In addition, there are 950 acupuncture points or major and minor junctures where two energy lines meet. Acupuncturists use these points as well the meridians to facilitate healing in clients.

The acupuncturist or Chinese physician makes an analysis based on the complex art of pulse-reading. They assess the energy flow in the system to distinguish which meridians are blocked and then manipulate the points to facilities the proper flow of energy: "Those who are experts in examining clients judge their general appearance; they feel the pulse and distinguish whether it is Yin and Yang that causes the health imbalance. Nothing surpasses the examination of the pulse for with it errors cannot be committed" (Veitch, 1949, p. 47).

Depending upon the analysis certain meridians points are manipulated. By inserting small silver needles into the meridians points and manipulating them, the energy-balance may be influenced and by doing so, healing facilitated. This may be done manually with pressure electric means or the ancient art of moxibustion, where heat and herbs are used directly on the skin (Askster, 1986).

While acupuncture is most common form of healing in Chinese medicine it is often used in combination with nutrition therapy and natural remedies such as herbs and minerals. A typical course of Chinese healing involves the use of acupuncture nutritional support and herbal remedies.

Spiritual Healing

Chinese healing acknowledges the presence of energy and its effect on the human body. The goal is to maintain a balance of Yin and Yang energy and the five elements. The technique of acupuncture is based on the principle of energy flow. Likewise, spiritual healing focuses on energy flow. Spiritual/energy-healers utilize the body's energy-field in both the identifying and healing of a variety of physiological and psychological dysfunctions.

Historically, the belief in the energy field is fundamental to many of the world's religions and spiritual disciplines. However, today in Western culture many especially allopathic health care providers view this energy and then spiritual aspect to healing with suspicion and fear. Despite this fearful atmosphere, there exists a large following of Western patients and healers that utilize the universal energy to facilitate healing. Furthermore, many individuals do so without their physician's knowledge (Harpur, 1994).

Proponents of spiritual healing state, that there are energy fields all around us. The most current word used to describe this field is the "Universal Energy Field." This field is also known by other names. In the Hindu tradition it is called "prana," in the Chinese "chi," and in the Greek "neuma." The Universal Energy Field surrounds the entire body and permeates every cell. Spiritual healers consider the energy field as containing the template for the human body. It is the vitalizing force upon which the body is created (Brennan, 1988; Wirkus, 1993). Therefore, its state is an essential indicator of health and considered an important element in the healing process.

Those who utilize the energy field for healing believe that the energy field is intimately associated with their health. The essential philosophy of those who perceive the field of energy is that this can be both an identifying and therapeutic tool. This tool may be used by those who train themselves to perceive the field and learn how to facilitate healing utilizing it (Brennan, 1993; Bruyere, 1989; Kunz, 1984).

The Universal Energy Field surrounds all living things. When discussing the energy that surrounds the human body, the term "human energy field" is used. The human energy field is closely associated with our physical, emotional, intellectual, relational and spiritual health. This philosophy of healing integrates several healing components. It utilizes the ancient Eastern concept of the chakra system as model of how energy is transmuted through the human body and energy field.

Essentially, this theory states that seven energy vortices exist along the spinal column. These vortetices or chakras take in the energy from Universal Energy Field into the human energy to them for proper health maintenance. Additionally, chakras correspond to other levels of being such as one's emotional intellectual relational and spiritual life. For example, the first chakra relates to one's physicality and sense of being in the world. It corresponds physically to the lower coccygeal area of the spinal cord and it's related energetically to the first level of the human energy field. Likewise, the second chakra corresponds to the reproductive organs is related to issues of sexuality and people's emotions. There are seven levels of the human energy field and seven chakras (Brennan, 1988). The entirety of the human energy field and seven chakras and our personal energy field, is intimately related to general health as well as the specific levels of being; mind, body spirit and emotions (Brennan, 1993; Bruyere, 1989). From this

perspective of healing illness has been attributed to disharmony of the organizing patterns of energy in a person (Bruyere, 1989; Kunz, 1984) or an imbalance of flow in the energy field (Brennan, 1993).

These authors indicate that the energy field can be "seen" when in an expanded state of consciousness. Furthermore, they say that entering such states may be facilitated through training. Once developing the ability to traverse levels of consciousness, a healer may expand their perceptual field such that they perceive the human energy field. While in this state, they perceive the energy patterns and make health assumptions. When in health, the energy field of a person flows easily and radiates bright colors. By contrast, an unhealthy field "appears" as darkened colors and health problem shows as stagnated areas where energy does not flow.

From a spiritual healing perspective health problems are a combined result of trauma (physical or psychological), either chronic and sustained, or acute and severe, environment, and genetic predisposition. Holistic (spiritual) healers contend that the result of trauma appears first in the energy field and last in the physical realm and body. In the beginning stages it will "appear" as a distortion, stagnation or block in the person's field or charka system. Then through time, if not released or if exacerbated by living habits and so forth, the initial stagnation of energy becomes more and more dense and of an increasingly lower vibratory rate until it manifests as an ailment in the physical body (Brennan, 1988, 1993). From the viewpoint of energy healing, interventions need implementation at the beginning the imbalance, on the energy level, where the precursors to physical illness begin.

Once healers identify an imbalance in the energy field, they work to clear the block, remove the dense energy and restore balance to the energy system and field. Healing occurs through the conscious and focused interaction of both the healer and the individual. The energy from the Universal Energy Field is transmitted via the healer to the client's persona; energy field is used for healing. Specific techniques are used to direct the energy to the health problem area within the field. Practitioners may "see" the healing taking place as the darkened colors become brighter and the field becomes clearer (Brennan, 1988, 1993).

Several things must be present for healing to take place. First, the healer must have the desire and ability to develop an expanded state of consciousness where ego attachment is held in abeyance (Brennan, 1993; Bruyere, 1989; Kunz, 1984). Also, the healer must be able to connect with the Universal Energy Field. Lastly, the healer must have the ability to focus their attention for long periods and "hold" the connection to the Universal Energy Field. The healer acts as both an instrument for the universal energy to flow through and technician who repairs damage to the personal energy field when necessary.

The historical underpinnings for holistic health provide a foundation for current holistic health practitioners and healers to learn from and be supported by. Hippocrates offers a concept of health which encompasses the whole person. Traditional Chinese medicine shows the important role one's totality of living has in maintaining health, including one's spiritual life. Additionally, it encompasses the concept of energy and opens the way toward encompassing techniques of energy-work to facilitate healing. The

modern-day energy/spiritual healers offer a philosophy of healing and techniques to utilize the Universal Energy Field for health maintenance.

Holistic healing developed over many centuries with contributions from many cultures. The original Hippocrates tenets adopted by the Western medicine were disregarded as the infectious health conditions seen primarily in the first part of the 19th century and then have been replaced by the stress-related and chronically debilitating illnesses of the latter part of this century. As medical technology reigned supreme causing medical costs to soar and the dissatisfaction of physicians to mount, the atmosphere for a radical shift increased and change became imminent.

The purview of holistic health care shows contributions from many philosophies of healing. From a holistic perspective many disciplines may be used to facilitate healing. One may address a health concern utilizing the best that allopathic medicine may provide. One may seek out homeopathic remedies to boost the natural healing process of the body. Additionally, one may intervene at the energy level, facilitating the balance of the field and the releasing of blocks in the human energy field.

From a holistic healing orientation, one may combine each of the healing traditions discussed and others, to use them alone, or in conjunction with traditional biomedical medical care. Healing Programs may be combined creatively depending on the needs of the client and the expertise of the healer.

Contemporary Theoretical Perspectives

Holistic Healing Today

Currently, varieties of disciplines discuss and research holistic ideas and concepts. Researchers from the fields of medicine, anthropology and psychology study the connections between the mind, body, emotions and spirit (Borysenko, 1994; Solomon, 1981). Additionally, one finds an increasing numbers of books devoted to the success stories of people who "cure" themselves of life threatening conditions with holistic healing techniques (Barasch, 1993; Kabat-Zinn, 1990; Moyers, 1994).

The emphasis across disciplines in academia and clinical training increasingly includes holistic ideas. For example, some physicians advocate for a recognition and training of intuitive mind for use when making diagnoses and treating patients (Solomon, 1981). Likewise, academic literature that discusses methods of inquiry and research advocates for the use creative/intuitive thinking process combined with traditional problem-solving techniques when developing and producing research (Bender, 1992).

In the realm of psychotherapy researchers discuss holistic ideas in the current literature. For example, Sirois in her research on spiritually oriented psychologists finds that her subjects who were all therapists valued expanding their view of knowing to include alternative (non-rational) forms such as intuition or guidance from a Divine source within the context of psychotherapy (Sirois, 1993).

Additionally, in Franks' (1993) study of the combination of psychoanalysis and meditation results reveal that combining the two disciplines increases therapists' ability to be empathic with clients. He finds that theoretical training in psychodynamic

psychotherapy coupled with a practice of mindfulness meditations allows therapists a more open and empathic experience of clients.

The aforementioned disciplines and others discuss and research holistic concepts. It is evident that investigating holistic healing crosses many disciplinary boundaries.

Regardless of the discipline most often the focus of research has been on the techniques of healing. This researcher found few studies that focused on the practitioners of holistic healing. Furthermore, the literature contains a noticeable absence of studies devoted to understanding the process of how one becomes a holistic healer. This is interesting, given the number of practitioners claiming to be holistic healer and advertising in publications as such. Given that holistic healers exist and that very few training programs exist explicitly devoted to training holistic healers, how do the practitioners become self identified as holistic? What is the process that moves an individual to be a forerunner in a field that others perceive as nonsense fantasy or merely the results of placebo effect (Vanderpool, 1984)?

We know very little about the phenomena of holistic healing. Although research about holistic concepts or healing techniques tells us some, little research focuses on the healer. Healing occurs in the context of a relationship. The importance of understanding both elements to the healing experience remains indisputable. However, despite this little research has been devoted to the healer's process. Therefore, this study seeks to add to the literature and address the practitioner's side of the healing relationship. It seeks to understand what process and experiences affected the practitioner's choosing a vocation in holistic healing.

Fundamental Elements of a Holistic Perspective

Holistic approaches by their nature recognize interdependence between the various aspects of human existence and promote a multi-level approach to health care. This multidimensional approach includes addressing and utilizing the person's mind and cognitive abilities, emotions and expressive capacities, as well as person's body and physical symptoms to facilitate healing. Additionally, a holistic approach addresses the spiritual element of illness and the person's connection to their spiritual self (Berliner & Salmon, 1980; Dossey, 1984; Gordon, 1981; Haggard, 1983; Patel, 1987; Relman, 1979). Research in the field of holistic health care agrees upon several fundamental characteristics that distinguish a holistic health perspective from traditional biomedical health care. Firstly, they view the healing relationship as a partnership, where each member is having their own expertise (Gordon, 1990; Rosch & Kearney, 1985). Researchers view the sick individual as an expert on his or her own experience and consider him or her a valuable participant in the healing process. The practitioner/healer's role in the healing process is to be a guide and participant and not the one who controls it. A holistic perspective acknowledges the power of the individual to make health enhancing choices based upon knowledge taught to them by their physicians (Berliner & Salmon, 1980; Dossey, 1984; Gordon, 1981; LeShan, 1992; Relman, 1979; Rosch & Kearney, 1985). Holistic healing often involves life style changes in addition to other suggestions. This kind of regimen depends on the person's responsibly following through with changes that may be counter to current lifestyle or nutritional habits and therefore difficult to implement (Ornish, 1995). The person's responsibility is regarded as crucial to healing outcome. Acknowledging this aspect

establishes a more equalized power distribution where the practitioner is guide, but responsibility falls on both participants in the relationship.

The definition of health from a holistic healing perspective has broad range of meaning. The holistic definition of health does not have fixed endpoints, but it is viewed as a continuum. More than the absence of ailment or symptoms, as is the prevailing biomedical definition of health, it includes at the upper end of the continuum qualities such as joyfulness, zest for life free flowing of feelings, joyous work and satisfying relationships. These characteristics are key components to a healthy life and as such are crucial aspect to "health." Although the holistic definition of health includes the absence of health imbalance and freedom from symptoms, it goes beyond and aspires to higher levels of health and well-being (Gordon, 1981; Whorton, 1985).

Likewise, the role of illness has a different meaning from a holistic orientation. Many proponents of holistic health acknowledge a spiritual component to illness and acknowledge that illness may have deeper meaning. As such, the exploration of illness' meaning and purpose is considered an important element to the healing process. Holistic practitioners view illness as an opportunity for growth, not simply something to be irradiated (Gordon, 1990). Therefore, they regard illness as purposeful containing lessons that may be valuable to the person's nonphysical dimensions-of-being. Thus, the importance of purpose and meaning are important areas of exploration in the overall healing approach.

A holistic perspective recognizes the importance of health promotion and illness prevention through altering lifestyle (Gordon, 1981; Relman, 1979; Whorton, 1985). The importance for habitual health promoting habits such as achieving a balance in nutrition

exercise and decreasing the ingestion of toxins such as caffeine, alcohol and processed sugar are crucial elements to health promotion and well-being.

While promoting the least invasive medical procedure first holistic practitioners acknowledge the importance contribution of surgery and chemical therapies when necessary (LeShan, 1992). A core tenet of holistic health includes discouraging the use of surgery as a first or even secondary healing option. The preponderance of addressing symptoms by invasive means is a common biomedical approach which runs counter to holistic ideals. Adherents to a holistic model of health advocate for the exploration of spiritual/psychical phenomenon and include these elements a healing program (Berliner & Salmon, 1980; Gordon, 1981, 1990; Patel, 1987). While recognizing the difficulty of proving via scientific means, the efficacy of some spiritual therapies clinical research and anecdotal accounts indicate that some spiritual healing methods do facilities healing (Murphy, 1993). Holistic practitioners advocate for incorporating spiritual methodologies including indigenous techniques as part of an overall healing approach (Berliner & Salmon, 1980; Gordon, 1981, 1990; Relman, 1979).

The Biopsychosocial Perspective

The Biopsychosocial philosophy and the discipline of psychoneuroimmunology closely related to this area of research provide good examples of holistic concepts and help answer some practical queries about holistic healing. Biopsychosocial researchers help answer the question of how each of these level-of-being (particularly the mind and body) affect each other. Many psychologists and medical doctors agree that to separate psyche from soma is futile. As it turns out conceptualizing human being as composed of

separate, no communicative and mutually exclusive parts is also scientific fallacy. Growing evidence shows that consciousness inhabits every part of us, even the smallest molecules in the body. Neuropeptides and their receptors the so called "messenger molecules," suddenly turn up everywhere in the body-in the brain (particularly in the center governing emotion) throughout the immune system and in many of the body's vital organs: "Our thoughts and feelings are mediated by neuropeptides, some diseases secrete neuropeptides, as they are key to the healing response" (Barasch, 1993, p. 47).

Recent research links physiological responses characteristic of some chronic conditions such as hypertension and heart disease to emotional causal factors as well as physical ones (Kabat-Zinn, 1990; Ornish, 1995). Some researchers speculate that organs that become sick have borne the brunt of persistent stress inner conflict or festering life issues their functions either overstimulated or suppressed (Borsenyko, 1994; Kabat-Zinn, 1990).

Emotional anesthesia is the very antipode of the healing path. For many getting in touch with so-called negative feeling becomes a gateway to greater aliveness and health (Barasch, 1993). Current research in the field of psychoneuroimmunology offers an explanation for this phenomenon. An American neuroscientist and pharmacologist Candice Pert in his research on brain and behavior discovered that the brain makes its own morphine and that emotional states are created by the release of these brain produced chemicals called endorphins. The astounding revelation is that these chemicals are not just found in the brain but in the immune system, the endocrine system and throughout the body. They are involved in a psychosomatic communication network (Moyers, 1994). In fact, researcher indicates that a link exists between repressing or expressing

feeling and the health of the immune system. For example, one references found that an individual who reported suppressing their anger had significantly higher levels of serum immunoglobulin A, a chemical that suppresses immune cell functions (Benson, 2000). Current research indicates a relationship between the brain and body and the role of emotions in the maintenance of health although the details of this relationship have yet to be clearly delineated.

One view of this relationship conceptualizes the mind located throughout the brain and body. Current concepts of the mind envision it not as a by-product of physiological thought common positions from a reductionistic orientation but as an enlivening energy in the information realm throughout the brain and body that enables the cell to talk to each other and the outside to talk to the whole organism (Moyers, 1994).

The Biopsychosocial model takes into account the missing dimensions of the biomedical model (Engel, 1980). The biomedical model can make provision neither for the personal as a whole nor for data of a psychological or social nature. The Biopsychosocial model recognizes the importance of lifestyle habits, nutrition and stress level to the state of health. Furthermore it values the research into the mind- body connection. Techniques of stress reduction utilizing the mind- body connection have been developed and tested indicating improved treatment efficacy when the connection between mind and body to utilized in healing regimens. However, despite the importance of the biopsychosocial philosophy to this investigation of holistic health and holistic healing, it does not account for the spiritual component to illness or to healing.

Spirituality and Pychotheraphy; Bridging East and West

When denuded from its religious context and defined more universally the role that spirituality may play within realm of holistic healing becomes apparent. William James discusses the concept of the "spiritual self" and defines it as ones inner subjective being and as the reflective process of abandoning the out ward looking point of view (James, 1902). Thus, spirituality involves a reflective process, a turning of our reflective gaze inwards. According to James the inner domain defines one's spiritual self. Meditation is a discipline that helps access one's inner/spiritual domain. The use Eastern meditative discipline in a holistic health program is an example of utilizing the spiritual realm in a total healing program.

The purpose of meditation is to enable one to become a detached observer of one's own mental activity so that one may thereby identify its habits and distortions (Kutz, Borysenko & Benson, 1985). There are several types of meditative disciplines.

Concentration meditation entails the mediator's focusing their attention on a single object or focus and seeking to keep their attention consistent with the single perception. Insight or Mindfulness mediators maintain their attention on a cognitive set of objects as they spontaneously arise in awareness (Goleman & Schwartz, 1977).

The aim of Mindfulness meditations is the full inward awareness of all content of the mind. In this way Mindfulness meditation is a procedure whereby inward reflection of the kind James Goleman referred to may be achieved.

The field of psychology offers perhaps one of the best examples of the integration of the spiritual realm in healing. Many psychologists and humanists have sought to integrate Eastern and Western psychology (Fromm, 1970; Suzuki & Assagioli, 1971).

This integration has occurred in response to what some feel is Western scientific approaches' failure to deal adequately with the realm of spiritual experience (Tart, 1975). In response, psychologists have developed a theoretical frame integrating developmental and ego psychologies of the West with spiritual and transpersonal psychology of the East (Wilber, Engler & Brown, 1986).

Relationship of Current Literature to Present Study

Important topics of the current literature to the present study will be discussed that might relate to the experience of healing, such as health status, recovery, and survival. In this related literature the independent variables such as social support, optimism, and hardiness are often well defined with reliable and valid measures. The dependent variables such as "being healthy, having minor health problems, suffering from chronic disease, being disabled, and being dead are treated as equally-spaced points on a continuum" (Hobroyd & Coyne, 1987, p. 364), and are not often well-defined or measured. Other measures sometimes defined as "healthy" are help seeking behaviours and compliance with medical recommendations.

Attempts are often made to define personality characteristics that relate to health and survival. Krantz and Hedges (1997) state that enthusiasm outweighs the evidence about how personality traits, psychological factors, and behaviours relate to health problem. Nevertheless, there are some interesting study in which attempt is made to measure the factors that might be relevant to holistic healing. The popular literature claims much more knowledge than can be substantiated with valid research, but this

literature has stimulated a research interest that may lead to more knowledge about healing.

Healing Techniques

In the literature related to specific techniques, such as biofeedback, therapeutic touch, imagery, and hypnosis, holistic healing is discussed directly. Each of these areas has a body of research, but the studies do not define healing and often do not give enough information for the reader to make a judgment on whether the outcomes are credible.

Imagery is thought to be promising as a healing technique (Achterberg, 2005). One type of imagery related to healing is the visualization of processes within one's own body that are used to promote specific physiological changes. Oncology has been the primary focus of healing through imagery, but research is being expanded into other illnesses, both chronic and acute. Achterberg states that imagery is capable on activating some internal mechanism, beyond the physical process. Based on clinical experience, not empirical evidence, she identifies the characteristics that relate to successful healing through imagery. Increased hope, self-esteem, and positive feelings were thought to be important. Relaxation and ability to focus on the imagery were considered essential for effective healing. The images themselves were best if they came from a thorough knowledge of the illness, but were not concrete (symbolic as opposed to anatomically correct). Ideally, images should incorporate visualization of the illness; effective medical techniques; and effective personal defense. The characteristics of successful imagery need to be tested empirically to gain more knowledge about the process of healing.

Holden (1995) conducted a study hypothesizing that relaxation with guided imagery would reduce the stress reaction related to surgery, lessening the cortisol levels and improving healing. She used an experimental design, having the participants' group listen to recorded relaxation and positive suggestion tapes prior to surgery. On each of the first three postoperative days they listened to tapes of relaxation and positive suggestion and imagery tapes describing progressive stages of normal wound healing. The control group remained quiet with no interruptions during a similar period of time. A wound healing instrument was developed by the author measuring edema, erythema, and exudates. Content validity was assessed by four experts using a four-point Hambeton scale. All items achieved three or four by all ratters. Pilot testing was done to assess inter-rater reliability. The other variables were measured by the state-trait anxiety inventory and laboratory measure of urinary free cortisol. Analysis of variance was the main statistical analysis. Anxiety patterns were found to be significantly changed by these applications. The pattern of urinary cortisol was not significantly different between groups. Urinary cortisol levels were then analyzed by the Dunn test and were found to vary significantly between groups on the first postoperative day. Wound assessment did not vary significantly between groups. It was thought that additional observations may have dictated more differences. Holden's study concludes that in some ways stress is connected to healing. Increased stress is thought to relate to a higher incidence of illness but this does not mean that the reduction in stress relates to healing.

Hypnosis has been considered to be similar to imagery and has been discussed by many authors as a means to assist healing. Hall (2003) reviewed the hypnosis literature on "cancer and the psychology of healing" (p. 2). The studies reviewed were most often

single successful cases. Occasionally, studies had five to ten subjects and one had 27. Issues of design were not addressed. One issue of control was addressed in several studies. The subjects of these studies were given the hypnotic suggestion to clear up a skin disease everywhere but one arm, or to have an allergic reaction on one arm and not the other. Statistical analysis was not done in even the largest study. Hall reports "healing" of skin rashes, warts, cancer, and positive tuberculin skin tests. There is no explanation or definition of the phrase the "psychology of healing."

Krieger (1994) discusses therapeutic touch as a tool to enhance healing. Practitioners are taught to focus intensely, thus redirecting the client's energies and transmitting a force of a well being to the client. Krieger identifies significant increases in hematocrit with the use of therapeutic touch. Increased hemoglobin presumably would increase the oxygen and electron carrying capacity of the blood, and enhance healing, but this connection was not clearly documented. No measure of holistic healing is discussed in the article.

Biofeedback requires the client's active participation in healing. The individual must do "something" with the mind to activate some physical change in the body. High blood pressure, Raynaud's syndrome, excess stomach acid, and headache have responded to biofeedback interventions (Pelletier, 1997). The results are usually symptomatic controls, rather than a more holistic representation of healing. Kewman and Roberts (2003) discuss biofeedback in general. They find that the studies are often not well-controlled. Studies show positive results, but when the studies are more controlled they do not support the idea that biofeedback directly mediates target symptoms. Biofeedback

is often associated with therapeutic results but it is unclear what is therapeutic and how it works.

Personality Characteristics

There has been much discussion about personality characteristics that relate to illness susceptibility. Problems exist with both the personality measures and the illness measures (Krantz & Hedges, 1997). Simonton and Matthews-Simonton (1994) have often been quoted after they have attempted to describe the personalities of survivors from cancer. They have reported these survivors to be receptive to new ideas and creative, though sometimes hostile, with strong egos. These survivors were rarely docile, usually in control of their lives, and had careers they liked. They were intelligent people with a strong sense of reality and though they were self-reliant, they also valued interaction with others. They were non-conformist with a permissive morality and an appreciation for diversity. They interpreted problems as redirection, not failure.

The actual study (Achterberg, 2005; Simonton & Mathews-Simonton, 1994) on which these results were based was not as definitive as it is reported to be. Subjects were drawn from Simonton's practice and fell into two groups, those who survived in excess of two years past an incurable diagnosis and an unmatched group who died within 13 months of their diagnosis. Differences in t-test means were reported as "significant." Other tests were reported as "approaching significance." The evidence appears weak or at least poorly reported from this frequently cited study.

Type A behaviour is a personality type particularly prone to coronary heart disease. There is no standardized questionnaire for this personality style, but only

structured, somewhat subjective interviews. Type A characteristics, thought to increase one's risk of heart disease, such as need for control, aggressive pursuit of goals, and outspoken behaviours, are surprisingly similar to the characteristics described earlier that Simonton and Matthews-Simonton concluded led to a higher rate of survival with cancer. That is, those characteristics thought to be useful for cancer recovery are thought to increase the risk of heart disease. This is a good example of how it would be unwise to take characteristics relating to health imbalance and to try to apply them to healing states, since they may not be the same even between different health imbalances.

Hardiness can be considered a personality characteristic. There were several subsequent studies in a scale measuring commitment, control and challenge. Commitment is defined as enthusiastic involvement in personal activities and a general curiosity and interest in other activities, things, and people. Control is a belief that one can influence events taking place around one. Challenge involves an expectation that life will change and these changes will be catalysts for personal development. Hardiness, the combination of these characteristics, is expected to produce optimistic cognitive appraisals and an increased ability to cope with stress. As illness is a stressful event, hardiness may be relevant to healing.

Kobasa, Maddi and Kahn (1999) asked whether hardiness functions to decrease the effect of stressful life events in producing illness symptoms. They tested 259 subjects using the Schedule of Life Events. Illness was measured through the Seriousness of Illness Survey, a widely used tool with no report of reliability or validity. Each of the scores, exercise, social support and hardiness was called a resistance score. This survey tested three hypotheses: subjects with three resistance resources are healthier than those

with two; subjects with two resistance resources are healthier than those with one; and subjects with one resistance resource are healthier than those with none.

Psychological Characteristics

Kiecolt-Glaser, Stephens, Lipetz, Speicher and Glaser (1994) studied DNA repair assays from 28 nonmedicated and nonpsychotic, newly hospitalized psychiatric inpatients to compare the speed of repair with psychological distress.

Speed of DNA repair relates to cell growth, cell division, gene expression and cell death. DNA repair is most often studied in relation to cancer but it could also relate to the physiology of healing. The Minnesota Multiphasic Personality Inventory was used to measure distress. DNA repair was measured at zero, one and five hours after blood samples were irradiated.

A low distress group shows significantly better DNA repair than the high distress group. Speed of DNA repair relates to cell growth, cell division, gene expression and cell death. DNA repair is most often studied in relation to cancer but it could also relate to the physiology of healing.

Optimism is a characteristic of particular interest since Cousins (1997) has reported his own survival from cancer through positive thinking. It has been only very recently that scientific studies have been conducted relating optimism and health. The study most relevant to healing involves a comparison of optimism and recovery from coronary artery bypass surgery (Scheier & Carver, 1996). Fifty-four subjects with no major psychiatric difficulties and under 58 years of age were contacted one day preceding their surgery when they were given the Life Orientation Test (LOT) (a scale measuring

optimism) and asked about their anticipated emotions and their typical coping strategies. Six to eight days after returning to the ward from intensive care the second contact was made. At that time they were tested with a social support scale. They were asked to report their mood and coping style, as well as satisfaction with care and specific expectations. A final contact occurred six months post-operatively to determine their quality of life. Additional ratings of physical recovery were obtained from the cardiac rehabilitation team, and medical charts were used to determine the extent of disease prior to surgery. The specific scales were not specified and reliability and validity were not reported. Optimists were judged to show a significantly faster rate of recovery than were pessimists. This was judged by the cardiac rehabilitation team, six to eight days post-operatively. Optimists were significantly less likely to develop new Q-waves on their EKGs (an indicator of myocardial infarction) and significantly less likely to have SGOT released at a level indicative of myocardial infarction. There was a positive correlation between optimists (as measured by a high LOT score) and quality of life (as measured by a high PQLS score) six months post-operatively. It is difficult to evaluate these results because of the sketchy information given, but these preliminary results appear important to the development of a fuller understanding of healing.

Levy (1998) conducted a study in which 34-first-recurrent breast cancer patients who had no previous chemotherapy were administered the Symptom Checklist – 90 (self-report psychiatric rating scale), the Affect Balance Scale (a mood measure), the Global Adjustment to Illness Scale (psychological adjustment for cancer), and the Karnofsky Scale (physical ability status). The subjects were stratified into living longer and shorter, with two years as the division point. Long survivors had significantly more positive

affect at baseline and significantly more joy than the shorter survivors. With the analysis of the result, an association is demonstrated between overall positive mood and living longer, a general negative baseline mood and hostility were associated with shorter survival. As there is increasing evidence that the nervous system can affect considerable control over the immune system, results of this sort may be relevant to healing. Reliability and validity of these scales are not discussed. Degrees of freedom are not reported with these results.

Transactional and Interactional Characteristics

Coping as a theoretical concept has been most extensively described by Lazarus and Folkman (1994). They divide it to include two processes: appraisal and coping. Appraisal evaluates situations with two questions: What is at stake? And what can I do about it? Stress develops if there is a discrepancy between the demands of the situation and the individual's perceived capabilities. Coping is a process of managing the discrepancy between external demands and internal resources to deal with those demands. There are two types of coping: coping directed at the situation; and management of emotional responses related to the situation.

Surgery is a stressful event that may require a coping response. Coping could potentially be part of the healing process.

Control has been defined as the perceived ability to have power over events, people, or condition. This control can also include a belief that one has the ability to regulate his own emotional response. Coping and control are strongly related in the literature and are often overlapping concepts. If one perceived himself as having control

he will expect to be able to manage the discrepancy between external demands and internal resources, and will therefore believe that he can cope (Lazarus & Folkman, 1994).

Bandura, Taylor, Williams, Mefford and Barchas (1995) discuss control, or at least perceived control, as an important factor in stress reduction. They devised a study monitoring plasma catecholamine to measure the stress response while spider phobics were taught to gain control over spiders. Actually, only ten subjects were able to attain a sense of control or coping self-efficacy. These subjects displayed a high epinephrine and nonepinephrine secretion when they doubted their self-efficacy. As their self-efficacy increased, their catecholamine reactivity subsided. The author concludes that there is increasing evidence that the nervous system (catecholamine) can affect considerable control over the immune system. Results of this sort may be relevant to healing.

Moch (1998) discusses a need for balancing control and un-control needs. She describes a societal norm that control is perceived to be the most desirable state, but there are times when one cannot have control. Un-control is an acceptance or the letting go of the need to control. She proposes that the nurse's role is to help the individual achieve a control and un-control balance rather than to always strive for control. Perhaps, the healing process includes an acceptance of reduced control.

Another interactional measure that has a large body of literature connecting it with health is social support. There are a variety of social support measures which have been compared with psychological and psychiatric symptoms, physical and somatic symptoms, use of health care services, blood measures, recovery from depression, physical and emotional recovery from an automobile accident and general causes of

mortality (Broadhead, Kaplan, James & Wagner, 1993). None of these are clearly healing, except perhaps recovery from depression or an automobile accident. It is generally thought that social support enhances health outcomes, but there is confusion about the multiple definitions of social support and whether it is quality or quantity that is important in social contact.

Mortality was related to social support in a nine-year follow-up study of a random sample of 2,229 men and 2,496 women between the ages of 30 and 69 were included in a nine-year follow-up study. In this study, social support was measured by marital status; contacts with close friends and relatives (measured by three questions); church membership; and informal and formal group association. Mortality data were collected from the Death Registry. All but 302 respondents were accounted for and for this group of 302 were not found to differ in their health profile from the larger sample. A chi square was used to analyze the data.

Men who were married had a significantly lower death rate than those who were not. There was no significant difference with women. More friends and relatives combined with a higher number of contacts were related to a significantly lower number of deaths. Church membership also was related to a lower number of deaths than non-church membership. Group membership was related to a significantly lower death rate in women only. The association between social ties and mortality was found to be independent from socioeconomic status, smoking, alcohol consumption, utilization of preventive health services, year of death, and self-reported physical health status.

This study is important because it taps such a large sample. As with any study of this size, potentially important details, such as quality of social contacts, are difficult to

obtain.

Kiecolt-Glazer et al. (1994) compared psychological modifiers to immunocompetence. They compared blood counts of natural killer cells (NK) (part of the immune system specific to antitumor and antiviral activity) were compared to scores on the UCLA Loneliness Scale and the Social Adjustment Rating Scale. The subjects were first year medical students, with a mean age of 23. Blood samples were taken one month after a major exam at the first day of final exam week. The tests were administered at the first or presumably low stress contact. An analysis of variance was used to analyze the results. A significant change in NK activity was noted between the first and second blood tests. Subjects with high life events scores had significantly lower NK activity and those who scored high on loneliness also had low NK activity. The authors conclude that stressful life events and loneliness both appear to be associated with NK activity. They also conclude that immune-suppression is associated with increased distress in a young and otherwise healthy population.

Lifestyle

Several health habits are well established as contributors to overall health and prolongation of life. The most conclusive health habits are sleeping seven to eight hours per day; eating a balanced, well-timed diet, including breakfast; maintaining a near-prescribed weight; not smoking; and regular physical activity (Califano, 1979). We do not know for sure that these same factors are relevant in healing, but we can speculate that their importance may apply there, as well.

Healing Practices

Healing practices throughout history, and in the present, have been and are varied and complex. Discussion of a few of these practices may add insight into the concept of holistic healing. The reliability of these reports is often difficult to judge since data gathering methods are not often discussed.

Healing for early Egyptians, Indians, Iranians, Babylonians, Greeks, and Romans related to the Gods. Illnesses were typically thought to occur when the Gods were angered. Charms, herbs, magic, and sacrifices were used to appease them. Sometimes the Gods who specifically related to healing represented joy, love, and music. Anger related to sickness and happiness to health (Jayne, 1955).

Historically, healing in China was tied to ancestors and religion. Explanations for illness related to loss of harmony with the environment, loss of harmony with people, and loss of internal harmony (Unschuld, 1985).

Originating from ancient Chinese medicine, modern Japanese medicine stressed the individual's duty to stay healthy, with proper diet, exercise, and a harmonious balance with the environment. Health imbalance could be internally or externally caused and healing is focused on achieving balance. Prevention was stressed and at times clients stopped paying their practitioners when they were sick, as it was their function to help keep them well. A sense of wholeness and harmony with the environment is a frequent theme.

Klienman and Sung (1989) conducted cross cultural studies in Taiwan and China, discussing two separate healing functions; one was the control of sickness, and the other was the provision of meaning for the individual's experience by helping the client

determine what is involved in the illness beyond the purely physical dimensions. Satisfaction with the indigenous healer was usually high, even when the condition did not improve. The person felt better in the second function of healing, even if not in the first, and was satisfied.

Modern and indigenous healing demonstrate some reported consistencies, but reliable research is difficult to obtain and it is unknown whether it is directly applicable to people brought up with different cultures. It seems important first to explore what the experience of healing is to the individual in a culture, and then to look for similarities or differences between different cultures.

Meaning Through Illness

Several theories have been proposed that relate to finding meaning in illness. Potentially relevant to the healing process is the concept, "health within illness." Instead of regarding one's illness as a totally negative experience, one can find meaning in their illness; use it as an opportunity for their reflection and growth. Illness can be a catalyst for feeling more alive or having more of a sense of connection with the whole.

Chick and Meleis (1996) discuss transitions as a passage or movement from one life phase, conditions or status to another. These transitions are positive and include a period of disconnectedness with confusions and distress, with potential changes in self-concept, self-esteem and role performance and leading to a sense of new beginning. As transitions can occur during illness or recovery the concept may be relevant to healing.

Steeves and Kahn (1997) explored a concept of meaning within suffering. In their contacts with hospice clients, they repeatedly heard them speak about experiences of becoming aware of something they considered greater than themselves and that these

experiences fundamentally changed the client's view of reality. This change was often a profoundly positive experience helping them to view their suffering differently, but more important changing their sense of themselves in the world. These people were dying and were having a different experience than people who are expected to recover but some elements are similar, such as anxiety, pain and changes in functioning. Finding meaning may be a part of the illness experience.

Summary

The most frequent discussions about healing have occurred in layman's literature. These books are often based on the author's clinical experience with empirical data that are inappropriately used or of poor quality. Healing itself is not clearly defined. This literature is popular, apparently appealing to some intuitive sense of holistic healing. Many of the ideas are worthy of note, but it is important not to accept them as accurate until they are scientifically tested. The data that have been used to support these theories often do not mention healing directly. Some examples of outcome measures were survival beyond two years, reduction of skin rashes or blood pressure, and increased hematocrit, cortisol or natural killer cells. Measures that seem more closely related to holistic healing, such as uncomplicated wound healing, quality of life after illness, and rate of physical recovery were less frequently used as outcome measures. Even these measures tapped only part of the typical conceptualizations of holistic healing that included a broader range of emotional, cognitive, physiological and behavioral changes.

CHAPTER THREE

DESIGN OF THE STUDY

Introduction

This study investigated the experiences of nine self-identified participants who experienced holistic healing. The overall research question sought to discover the experiences that contributed to the mechanism of holistic healing. Additionally, the study sought to clarify and understand the phenomenon of holistic healing. While the study intended to understand and explore personal experiences, an additional goal was to remain open to novel themes going beyond the predetermined categories. Therefore, this study used a qualitative, semi-structured phenomenological method to gather information.

Participants

The number of participants in a phenomenological study as arrived at while the study is in progress and is determined when the phenomenon seems to have been thoroughly explored, indicated by the researcher experiencing redundancy (Parse, Coyne & Smith, 1985). The goal is depth, not breadth. Little of value is learned after core categories have been saturated (Glaser & Strauss, 1987). When new participants begin to

repeat the same ideas about a concept that have been discussed in depth by prior participants, that concept is saturated.

In this study a target number of seven participants were chosen. Nine participants were actually interviewed. Although the core categories were saturated after seven participants, the eighth participant demonstrated a number of unique behaviors prior to surgery that appeared as if they might add important insight to the study. The ninth participant was a man and it was thought a second male perspective could be valuable. Information from the eighth and ninth participants strengthened the data but it did not make known any major insights. This reinforced the notion that the major categories had indeed been saturated.

In phenomenology it is important to choose participants who are able to speak with ease, express their feelings, and describe physical experiences (Van Kaam, 1966). All the participants were very verbal and expensive and seemed to have little trouble discussing their healing experiences.

Although healing occurs frequently in everyone's life, it was desirable to have a profound event that would focus the participant's attention on the healing process and would be defined by the participants as healing. Participants were chosen who:

1. Had had recent surgery (first interviews were conducted one week after hospital discharge).
2. Were expected to return to their pre-surgical level of functioning.

To insure that the participants would have a significant enough surgery to focus their attention on healing, they:

1. Were in the hospital for at least three days except for the ninth participant for whom surgery was very significant despite his two-day hospital stay.
2. Were not expected to return to pre-surgical functioning for at least three weeks.

Certain situations related to the surgery could have distracted the participants from focusing on healing. It was not assumed that these situations could not be healing experiences, but individuals with the following characteristics were not included:

1. External disfigurement from the surgery, beyond the incision.
2. An illness that was expected to be fatal.

Two pilot interviews yielded some potentially important differences between people who had no prior surgical experiences and those who had had prior surgical experiences. That is, memories of prior surgery produced expectations and preparation while the person having surgery for the first time had a more naïve view of the experience. The pilot study will be described in more depth later in this chapter. It was intended that approximately one-half male and one-half female participants in order to tap the potential gender differences in the experience of healing. It was much more difficult to find male participants than was anticipated, but the two men in the study gave at least some male representation. All the participants were between the ages of 21 and 65.

It seemed important to allow the participants' time to establish some order in their lives, which were likely to have been disrupted by hospitalization. The first interview was not conducted until one week after hospital discharge to give participants time to attend to neglected family, adapt to possible changes in mobility and deal with issues

such as unpaid bills and depleted food supplies. It is assumed that healing would begin as soon as the surgery was completed. Waiting for the first interview was intended to reduce distractions and does not imply as a place where healing begins.

Demographics

Of the nine participants, two were men and seven were women. Their ages ranged from 28 to 65, and the mean age was 44. The participants had a variety of occupations. One was a clerk in a clothing store, one managed a small rental operation, one was a marketing manager assistant for an architectural firm, one was a housewife, one was a program director in an addiction center, one was a staff coordinator in a large company, and two were attorneys, one in solo practice and the other a partner in a medium-sized law firm. Seven participants were Caucasians, one was a Japanese, but born in the United States. One participant was Jewish. One participant lived alone and another lived alone most of the time but at the time of the first interview her son, her daughter-in-law and three grandchildren had been living with her for a few months. These family members had all moved out by the second interview. Two participants lived with roommates, one lived with her two sons, two lived with their mates and children, and two lived with their mates only. Participants' age, occupation, degrees held, income level, marital status, living arrangements and other specifics for each individual participant can be found in Table 1.

Table 1

Demographics

Participants	Sex	Age	Occupation	Educational	Income	Living Arrangement	Marital Status	Ethnicity
1. Annie	F	33	staff coordinator	B.A.	$20-40,000	husband, 2 children	Married	white
2. Brent	M	35	shop manager	2 yrs.	$40-70,000	wife, 3 children	Married	white
3. Catrine	F	32	marketing	B.A.	$10-20,000	husband	Married	white
4. Dorish	F	65	housewife	B.A.	?	husband	Married	white
5. Erikate	F	28	attorney	J.D.	$40-70,000	roommates	Single	Japanese/ American
6. Feona	F	63	clerk/ housewife	high school	$20-40,000	2 sons	Widow/ divorced	white
7. Gayley	F	58	program director	2 yrs. college	?	alone after daughter and son left	Divorced	white
8. Helena	F	45	word processor	B.F.A.	$10-20,000	alone	Divorced	white
9. Ivani	M	39	attorney	J.D.	$20-40,000	roommate	Single	white/ Jewish

Physical Health Practices and Status

Six participants were of normal weight. One participant appeared to the researcher to be about thirty pounds overweight and two defined themselves as ten and fifteen pounds underweight. All of them considered their general nutrition to be good except one who ate one very large meal per day and consumed five pots of coffee per day. He was the only participant who smoked. The other participants had never smoked

except one who quit ten years ago. Five participants considered themselves to be excellent health and four classified themselves as having good health when asked to rate their health as: excellent; good; fair; or poor. See Table 2 for details related to each participant.

Table 2

Physical Health Practices and Status

Participants	Weight	Nutrition	Exercise	Self-Classification of Health Status	Smoking
1. Annie	normal slim	good	yes	excellent	no
2. Brent	- 15 lbs	one large meal/day	no	good	yes
3. Catrine	normal	good	yes	excellent	no
4. Dorihs	normal	good	yes	excellent	no
5. Erikate	normal slim	good	yes	good	no
6. Feona	- 10 lbs.	good	yes	good	no
7. Gayley	+ 30 lbs	good	no	good	quit 10 years ago
8. Helena	normal	good	yes	excellent	no
9. Ivani	normal slim	good	yes	excellent	no

Surgery

The participants had a variety of surgical procedures. Two had intestinal resections, one had an inquinal herniorrhaphy, one a hysterectomy, one a removal of one ovary - partial oophorectomy, one a hip replacement, one an anterior cruciate ligament reconstruction, one a knee reconstruction with bone graft, pins and a plate, and finally, one had a spinal fusion with a bone graft. They averaged five days in the hospital with a range of two to nine days. All except one participant had prior surgeries. One person considered herself to have returned to full functioning at the time of her second interview. The rest had not yet returned to full functioning. One person went back to work full time within ten days of her surgery. The others returned more gradually. Of the seven who started working half-days, it took an average of twenty days to return to that point with a range of five to thirty-five days. Not everyone had returned to full-time work by second interview, but five who had, took an average of thirty days, with a range of ten to forty-nine days.

It was thought that pain perception might relate to healing and all participants voluntarily described their experience of pain. These experiences differed greatly and the severity of pain did not always relate to the severity of surgery.

Participants also had different recovery complications. One participant's recovery was complicated by fluid in her lungs, another's by fluid in his lungs and weight loss, another's by chest rattle and hematoma on her graft site, another's by weight loss and severe gas pains. Two participants had developed chest colds, one had developed incision infection and had to be placed on double doze of antibiotics, another had severe reaction to anesthetic but no lasting complications, and another had developed

constipation as a side effect from pain medication. See Table 3 for a comparison of surgical experiences.

Table 3

Surgery

Participants	Age	Type of Surgery	Days in Hospital	Complications	Prior Surgeries	Days to Return to Work ½ Days	Full-Time	Pain
1. Annie	33	- intestinal resection	5	fluid in lung	same	18	38	minimal
2. Brent	35	- intestinal resection	7	fluid in lung, weight loss	cholecystectomy	29	33	moderate
3. Catrine	34	- partial oophorectomy	3	severe allergic reaction to the anesthetic	none	14	21	minimal
4. Dorish	65	- hip replacement	8	chest cold	same	N/A	N/A	minimal
5. Erikate	28	-anterior cruciate ligament reconstruction	3	chest cold	herniorrhaphy	N/A	10	moderate
6. Feona	56	- hysterectomy	6	weight loss gas pains	tumor in thigh, mastectomy	28	N/A	minimal
7. Gayley	58	- knee reconstruction	9	chest rattle, hematoma	hysterectomy Jennetta procedure Lumpectomy	35	49	severe
8. Helena	45	- spinal fusion	4	incision infection	same	30	37	moderate
9. Ivani	39	- inguinal herniorrhaphy	2	constipation from pain medication	appendectomy	5	12	moderate/ Severe

Methodology

The Setting

An attempt was made to interview all participants in their homes as it was likely to be a place where they felt comfortable and were sufficiently relaxed to be able to talk about their experiences. The home was also chosen as a more appropriate setting than the hospital. Although healing probably does not occur in the hospital, many factors are present which may influence the ability to focus on the process. Pain, recovery from anesthesia, lack of privacy, and immersion in the "patient" role are notable destructors which are expected to be less pronounces at home.

Most of the interviews were indeed conducted in the home, but the second and third participants both found it more convenient to be interviewed in their office for the second contact. The fifth participant had returned to work by the first interview and wanted both interviews to be conducted in his office, but at the last minute he called to say he needed to get away from his office, and to ask whether it would be possible to meet in a restaurant. The interview was conducted in a restaurant close to his office.

Gaining Access

Three surgeons known to the researcher were contacted by telephone and then by letter (see Appendix A). One was willing to provide participants for the study. One surgeon had retired and the other was focusing on surgeries that did not meet the criterion for the study. They both provided names of colleagues who might be willing to help. The one who had potential participants provided the first three individuals for the study. At this point participants became much more difficult to find than was anticipated. Seven

more surgeons were contacted after they were recommended by other physicians known to the researcher. All of these surgeons said they would be willing to help, but none provided any participants. Through the state and country Nurses' Association names were obtained of two nurse anesthetists and three nurse coordinators in surgical practices. Each of these people said they could be of help, but no participants were gained through them. Through the researcher's own private practice she had many contacts with physicians, lawyers, personnel departments and other referring sources. The need for participants was expressed to many of them. Four participants were gained from these sources. Two participants were referred by professional friend. These participants were not known to the researcher or each other.

All the participants were given the researcher's telephone number and a brief description of the study (see Appendix A). It was left to the potential participants whether they would make the first contact. Their participation in the study was never discussed with referring person.

The researcher had assumed that access to participants would be much easier that it was. The resources who were able to provide participants all knew and trusted the researcher. This knowledge could have made it easier to believe that patients would not be harmed by participation in the study. More personal contact beyond telephone and written contact may have helped to build the necessary trust with potential providers of participants who had never met the researcher.

Once the surgeons or nurses agreed to help locate participants for this study, they often delegated the responsibility of talking with the patients to other staff who were more removed from any interest in the study and less likely to cooperate. They were

often very protective of their employer and seemed leery of anything that might create more work for him or for her. Several of the participants in the study saw no benefit in talking about their experience (even though they were willing to talk for the study). If this is a common characteristic, it may have influenced potential participants' decision not to participate in the study.

Because of concern for protection of human subjects, potential participants were responsible for contacting the researcher, not vise versa. This may have added to the difficulty of finding participants. Perhaps more potential participants could have been contacted sooner to insure a less prolonged interview schedule.

Phenomenological research is a relatively unknown methodology in the medical community and potential providers of participants may have been concerned about the validity of the research.

After the potential participants called the researcher, a short interview was conducted on the telephone to ascertain whether they met the requirements for the study. They were told what would be expected of them and asked whether they were willing to participate. An appointment for the first interview was set up at this time.

Human Subjects Consideration

Participants were informed about the nature of the study verbally and through a written consent form (see Appendix A). The nature of the study was also discussed over the telephone and at the start of the first interview. Questions about the study were answered at this time, as well as later. As stated in the consent form interviews were tape-recorded. The tapes were transcribed by the typist. Pseudonyms were substituted

whenever the participant's name was used on the tape. The tapes, transcriptions of the tapes, information sheets, and any other materials written by or about the participants' actual names do not appear in any written reports, nor will they be used in any other way. A list of participants wishing information about the results was kept separate and was in no way connected with the data. Participants were assured that they could withdraw from the study at any time, and that this would not affect their healing in any way.

It was not anticipated that the questions would cause any emotional trauma, but the participants' emotional state was assessed throughout the interview and time was allotted to discuss any difficulty they had.

Time Frame

The first interview was intended to be conducted approximately one week after hospital discharge. In fact, eight participants were interviewed during this time frame. One participant was interviewed two months after discharge. The first variance was a convenience to the participant and the long interval was accepted by the researcher to add a second male perspective. Only one interview was done with this ninth participant because he was not in the same rapidly changing phase of healing as the other participants.

The second interview was planned to occur three weeks after the first interview to allow enough time to pass to have some additional thoughts on healing, yet to be early enough in the process that the participant was still focused on healing. Because of scheduling problems the interviews were a few days earlier or later than planned. This

was not considered a problem as the attempt was to observe a process, not to explore a precise time sequence. See Table 4 for interview schedule.

Table 4

Interview Schedule

Participants	Date of Surgery	Hospital Discharge	Interview #1	Interview #2
1. Annie	3/10/09	3/15/09	3/25/09	4/16/09
2. Brent	3/11/09	3/18/09	3/25/09	4/16/09
3. Catrine	3/12/09	3/15/09	3/23/09	4/15/09
4. Dorish	3/16/09	3/24/09	4/1/09	4/23/09
5. Erikate	3/17/09	3/20/09	3/28/09	4/18/09
6. Feona	3/18/09	3/24/09	4/3/09	4/24/09
7. Gayley	3/23/09	4/1/09	4/9/09	4/27/09
8. Helena	3/24/09	3/28/09	4/7/09	4/28/09
9. Ivani	2/2/09	2/4/09	4/13/09	

Studies reporting healing after the hospital stay are rare (George & Scott, 1982). Yet the importance of the time after the participants' return home seems self-evident. When individuals leave the hospital they almost always have a period of time before they can resume usual daily activities and a longer period before the impact of the surgery has diminished. Healing was thought to occur over time, but it was unknown how much time. The time frame of this study was considered to be a slice in the healing process and

two interviews were conducted to sample more than one point in the process. The ninth participant, who was interviewed two months after his surgery, extended this time frame. It was recognized that healing would probably continue for many months, but due to practical time constraints, the inability to define the end point, and the likelihood of the participants' attention being most focused early in the process, it was considered appropriate to interview during the first weeks of healing

Preparation for the Study

Prior to designing the study the literature was examined to assess the state of knowledge about healing. This was a general overview to examine the state of the literature, yet avoid potential bias. There was found to be little in the literature directly related to healing so the risks of bias from this source were thought to be minimal.

Bracketing of presuppositions about healing was the next step. This was accomplished in several ways. An extensive log entry following the question "Why am I interested in healing?" was written. A list of assumptions was identified (see Appendix B). Both those documents were read by several reviewers who, in resultant discussions, helped to refine and define these presuppositions. These reviewers included a designated peer review group and academic advisors familiar with this type of research. As presuppositions can either interfere with or enhance data collection and analysis, and can change during the process of the study, bracketing was continued throughout the study. This was accomplished through personal reflection, log entries, and peer review group feedback.

The peer review group consisted of several students who were also involved in doctoral dissertations using qualitative methods. The log was a personal journal kept throughout the entire study that contained personal reflections, notes about feedback from advisors and peers and general thoughts about the study that did not relate directly to the data.

Pilot Study

The next step was to conduct a pilot study. Collaizzi (1998) suggested the use of a pilot study to determine and refine the appropriate questions to be used. Pilot interviews were also recommended by Gordon (1990) who stated that they were necessary to determine the best type and order of questioning. He suggested that unexpected inhibitions, participant ability to handle the questions, and problems of style and flow would become apparent before the study began. The pilot also gave the researcher the experience of using her established interview skills in a phenomenological format, and to apply her knowledge of coding and theme development to the specific subject of this study.

Two pilot participants were contacted by a nurse colleague who received their permission for the researcher to call them. The first participant was a 56-year-old woman who considered herself in good health prior to surgery. Surgery was a hysterectomy with high suspicion for malignancy, but was in fact a benign but very large tumor with several complications. She had had two prior surgeries in 1994 and 2005. Two interviews were held in a quiet room in her office, which she preferred over her home.

The second participant was a 34-year-old woman who considered her health excellent prior to surgery. This was her first surgical experience. Surgery was expected to be a hysterectomy, but in fact was only partial oophorectomy. The result was a happy surprise as she and her husband wanted children. The interview was held in a restaurant near her work. The pilot information sheet can be found in Appendix D. The pilot interview guide can be found in Appendix E, while the findings of the pilot study are shown in Appendix I.

Both initial interviews lasted 70 minutes. The first participant was interviewed a second time for 60 minutes, the second participant was interviewed a second time for 40 minutes, making a total of four interviews. Neither participant had any difficulty with the questions and both were able to articulate their thoughts and feelings. The data were coded and preliminary themes were defined. The preliminary themes were identified: control; need to talk; emotions; purpose versus boredom; memories and expectations; social support' environment; physical issues; spirituality; and time to heal.

Through analyzing the pilot data, some modifications of the questions seemed appropriate. One question was eliminated as too confusing and two were added. The confusing question was: "At different times since surgery, have there been different things happening that are part of healing?" A question was added specifically asking about spiritual issues relating to healing because both pilot participants discussed this area. Another question asking about whether participants experienced a need to talk about their illness was added because one participant found this to be important. These specific questions were asked, in the actual study, after the participants were given the opportunity to describe their experience in their own way.

Data Collection

Information Sheets

Demographic and health data were obtained through an information sheet that was completed by each of the nine participants at the end of the first interview. Many of the participants related to healing as opposed to what the researcher thought was relevant (see Appendix C). This format elicited little information, and it was thought more information would have been obtained with more specific questions. For example, a typical answer to the question "Do you do anything specific to maintain your health?" was "good nutrition, exercise," or just "no" or "yes." The other two broad questions yielded even less information. Many sections were left blank. The original questionnaire used in the pilot study had yielded more information, but it was modified to stay more closely with the phenomenological style.

The Interviews

In a phenomenological study, the purpose of the interview is to elicit information about the participants' experience in their own words, order of priority, and depth of emphasis. The interviews lasted from 60 to 90 minutes.

The first question the participants were asked was a broad open-minded question with neutral probes to elicit the participant's own experiences, in the context and order they were experienced (Gordon, 1990). More specific questions were asked only after the participant's own discussion of healing in general had been exhausted. Gordon recommended developing an interview guide that has a general goal and central purpose,

yet does not intend to ask identical questions in a specific order. A guide was developed for this study and modified in the light of the pilot interviews (see Appendix E).

After the first interview with each participant, the data were analyzed to discover whether any of this information needed clarification or expansion or whether any of these data pointed to the need for another area of questioning. A list of specific questions was drawn for each participant to explore during the second interview (see Appendix H). The second interview started with general questions before the more specific questions were asked. Again, the purpose was to elicit the participants' experience in the most uncontaminated way possible. The participants' thoughts about the healing appeared to be stimulated by the first interview so that they add new ideas to express during the second interview and validate the emerging themes and interpretations of the researcher. For example, the importance of having a positive attitude was an early theme that required more in-depth questioning. The purpose of the journals was to offer an alternate means of communication and to keep a record for better recall of ongoing thoughts about healing. Only one participant wrote belief notes in this journal. Participants stated that writing their thoughts did not come easily to them and that they had trouble concentrating on that type of task at the particular time after surgery when concentration in general was often a problem.

Treatment of the Data

As the data took a variety of forms, a list of data records has been complied in Appendix J. All the interviews were tape-recorded because this method allowed for the most complete data. If everything is recorded, the relevance of the responses could be

decided later (Gordon, 1990). In phenomenology it is important to consider the relevance of everything the participant says in relation to the phenomena (Giorgi, 1995). Each tape was transcribed by a typist who was instructed to reduce verbatim. The researcher listened to the tapes while reading the transcriptions, and notes were made about emotional responses, tone, pauses, or anything else of note that was not noted in the written form.

Data Analysis and Assumptions

Data Analysis

The first interviews of the first two participants were conducted on the same day, but no further interviews were conducted on the same day until these data were preliminarily analyzed. It was important to begin to establish hunches about the data between the first and second interviews of each participant, and then ask for clarification or more depth about ideas that appeared important. The second interview for the first two participants also occurred on the same day three weeks later. These two second interviews preceded the first interview of the third participant in order that the data could build on itself rather than having isolated unrelated interviews. Following the third participant, the interviews were spaced with ample time to analyze and reflect on the data.

In keeping with the phenomenological method, data were analyzed from the perspective of the participants' experience as opposed to interpreting non-stated meaning that may also exist. Each interview was read in its entirety in order to attain a sense of the whole. Coding was begun after reading the whole interview. Codes were developed

from a personal reaction to the data. It was asked, "What is the meaning of this phrase or paragraph?" Each section could have multiple meanings and all possible meanings that came to mind were added. For example, a statement about needing to return to one's prior level of exercise could be labeled Ph.Ex.Fu (Physical exercise and functioning) and Ps.Gl.Ct (Personal goal and control). This one statement could then be examined under exercise, functioning, goals and control. It was found that the broad categories such as "Physical" were not useful and they were ignored in the analysis. Codes were modified and each time a new concept arose and as modifications occurred, already-coded data were recorded so that all the data were treated with the same set of codes. See Appendix K for the final list of codes.

All sections of the data were coded. This required repeated readings of the data. Some sections of the data required multiple codes since more than one concept was represented at one time. Statements thought to be particularly important were underlined. Coding was interrupted any time there was a hunch or idea in the data about what was being said. These ideas were recorded as analytic memos.

Glaser (1998) discusses memos as momentary ideation that helps to raise the data to the conceptual level. Each memo was typed, titled and dated. Each was on separate sheet of paper so that they could be easily sorted. Memos served to begin to connect section of data, show that a certain piece of data is an instance of general concept, remark on puzzling or surprising data, or explore nuclear ideas that may find clarity through writing about them (Miles & Huberman, 1994). Occasionally, memos explored problems with the analysis, question wording, or other implementation issues. See Appendix F for an example of memo.

Codes and memos were then grouped together to produce approximately 40 categories including such topics as death, pain, emotions, and functioning. See Appendix L for a total list of categories. These were alphabetized for easy management. Each category was read and re-read for meaning. Hunches about themes began to emerge. These hunches were then compared with actual data to see if they were substantiated. It was repeatedly asked whether the generalized statements were represented in the data. Peers were asked to read sections of the data with this same question in mind. If they were substantiated, a combined description was written using quotes and descriptions from the data to build subthemes. These subthemes included 24 categories such as attitude heals; mind-body incongruence; temporality; and accurate anticipation. See Appendix G for a complete list of subthemes.

These subthemes were then examined with diagram, questions and discussion (with peers and advisors). Clusters of subthemes were examined asking the question "Does this cluster represent the whole and is the whole represented in this cluster?" Through this process three major themes emerged: Active Participation; Achieving Balance; and Evolving Beyond. Each of these themes overlapped with one another, yet retained a unique integrity. Each was thought to represent the whole and accurately described the participant's experience. Each theme contained several of the subthemes and all the subthemes were included in at least one major theme (again, see Appendix G). Colaizzi (1998) describes a process of creative insights where one goes beyond the data, yet stays with it. This allows a creative leap but does not allow one to generate data that does not exist. For example, categorizing the 25 subthemes under three major themes

and process theme required a creative leap, yet care was taken that all the data were represented in these major themes and that the themes continued to represents the data.

Participants were re-contacted to find out whether they agreed that the themes accurately represented their experience of healing. The participants were asked to review the developed themes and to comment as honestly as possible as to whether the description (which was a conglomerate of all the participants' comments) captured their experience of healing. They were encouraged to write on the copy of the description and to fill out a questionnaire that asked which parts of the description they had read. All participants had read the entire write-up. They were also asked which parts related to their experience, which did not relate to their experience, other reactions they had to the data, and whether their level of functioning was better, the same as, or worse than before surgery.

Four participants returned written comments. Five participants commented verbally after not returning the questionnaire and being contacted and interviewed over the telephone.

Participants agreed that their experience had been captured. They reemphasized the importance of areas such as having a positive attitude. They also added some new thoughts about the continuing process. For example, one participant who had originally needed privacy no longer needed it, indicating privacy for her was a temporary stage of healing. The rest of the data was then reexamined to find that privacy was often temporary for the other participants, as well. The written and verbal comments from the third contact with participants were incorporated into the results.

After the themes were developed, the literature was explored to look for information both supporting and refuting this conceptualization of healing. The comparison study with the literature can be found in Chapter Two.

Trustworthiness

Sandelowski (1995) discusses rigor in qualitative research in general. She stresses the importance of applying appropriate measures of rigor so as not to lose the advantages of particular types of research. If quantitative standards of rigors were applied to qualitative work, the advantages of qualitative research could be lost. Lincoln and Guba (1990) discuss trustworthiness in qualitative studies under the headings of credibility, transferability, dependability, and confirmability. These guidelines were used to establish rigor in this study.

Credibility

Credibility has to do with whether the data faithfully describes and/or interprets human experience. A number of techniques were employed to increase the chances that these nine participants' healing experience was accurately described and interpreted. All interviews were transcribed verbatim, reducing the chances of inaccurate recording or recall. Sufficient time was spent with the participants to develop a working relationship, to assess whether they were having difficulties with the questions, and to allow them to thoroughly describe their experience. The three weeks between interviews allowed participants time to further develop their thoughts about healing and added a temporal

dimension. As human experiences such as healing occur over time this longitudinal aspect could increase the accuracy of the resulting description.

Sandelowski (1995) suggests asking subjects to read the synthesized descriptions of the phenomenon to verify it as actually representing their experience. All the participants read the synthesized description and commented in writing and/or verbally.

Using more than one type of data source or triangulation of data sources was done to improve credibility. Data were obtained in both written and verbal forms. Written forms included participants journals and dairy (see Appendix M and N), follow up questionnaire (see Appendix H), and information sheet (see Appendix C). Verbal data sources included interviews and telephone contacts to clarify points during data analysis and after data analysis to request that they read and comment on the themes. During this last telephone contact the participants often talked about their progress and additional thoughts.

Bracketing of presuppositions also contributed to credibility. This occurred through personal introspection and log entries as well as regular peer review. Peer review was accomplished through a group of doctoral students who were also in progress of conducting qualitative studies and by presenting portions of the data to a "qualitative interest group" composed of faculty and students. Peer review was used as a feedback system, a place to air hypotheses to prevent premature conclusions, and for catharsis to reduce emotional clouding of one's judgment (Lincoln & Guba, 1990). Log entries were made following each peer review.

The researcher also had members of this peer group check the coding that was used in analyzing the data, to verify that the data extracted was representative of the

participants' viewpoint. They also checked to see if potentially important information was not extracted. This was accomplished by giving several randomly selected sections of the transcripts to group members who applied the established codes and un-coded transcript. The results were compared to the researcher's coding of the same section. Discrepancies were discussed, but in general it was found that the coding of the reviewer corresponded with that of the researcher. As the themes emerged, their connection to the coded data was verified though discussion.

Transferability

Transferability is established when audiences outside the subject group find the study meaningful and applicable to their live (Guba & Lincoln, 2001). The findings of the study were given to three people to read and comment. One person was a professional acquaintance with a Ph.D. in psychology who had a chronic illness with remissions and exacerbations. He particularly identified with the privacy of the healing experience. Two others (both close friends) had had numerous surgeries and they concurred with the major themes in that they found each other relevant to their own healing process. If transferability does occur after publishing the results, it can be used for additional support for pursuing further research.

Dependability

Dependability pertains to whether another researcher might follow the steps and decisions in the study (Guba & Lincoln, 2001). That is, is it possible to audit the study? This was accomplished by clearly defining the steps that were taken to carry out the

study, and documenting all decisions and changes from the steps described in this section. A process diary documenting and dating each step was written (see Appendix N). Before the interviews were started, the proposal was reviewed by a colleague, unfamiliar with the methodology. It was established that she could understand how this study was to be conducted, because she could accurately describe the steps of the study.

Confirmability

Confirmability is whether it can be established that the findings are based in the data; inferences based on the data are logical; themes have explanatory power; and negative evidence has been taken into account. A study is confirmable if the records are available for the audit to be carried out. The record-keeping process must be detailed enough and well enough defined for another person to follow the decision trail. In this study, confirmability was established through carefully recording raw data, data reduction and synthesis products, process notes, personal notes, conglomerate description, and evidence of credibility, transferability, and dependability (Lincoln & Guba, 2005). The List of data records in Appendix J uses these headings to define the data.

Data Assumptions

To conduct this research, the researcher interviewed the participants with an open mind, analyze the interview data and present their experiences accurately, the assumptions and biases of the researcher need delineation. This action seeks to decrease the likelihood that these biases will interfere with the interviewing or analyzing process.

Additionally, the reader becomes more informed about the instrument of this research and can, therefore, critically regard the results of this study.

Summary

In summary, this chapter identified the study's design of achieving a more complete knowledge about holistic healing. Ultimately, understanding this human experience will assist in promoting holistic health. The methodology for this study examined what is holistic healing, coupled with inadequate understanding and research regarding matters of people's experiences of holistic healing. Asking people for their impressions regarding their healing experience would reveal the importance of relying on the client as the most important information resource. Hence, this phenomenological study was conducted.

CHAPTER FOUR

RESULTS AND FINDINGS

Introduction

The experience of healing as perceived by participants in this study was an active, involving process with movement toward achieving balance and wholeness and the individuals evolving beyond the place they started before surgery. The data clustered into three substantive themes: Active Participation; Achieving Balance; and Evolving Beyond.

Analysis of Data

Active participation involved an understanding that healing does not just happen, one needs to make it happen. Participants acknowledged that part of healing goes on regardless of their intervention, but that was not the part they experienced, except to monitor the results. Participants actively sought control of their body, their activities, their attitude, and their privacy.

Achieving balance was a process of returning to feeling like an integrated system that did not need monitoring. For a time participants felt fragmented with swings between pushing too hard and then becoming exhausted; requiring extensive rest. The

mind and the body seemed out of sync and there was a desire to reintegrate their functions.

Evolving beyond was a process of life healing or attending to more than the immediate recovery. The participants examined goals and values. They reviewed past events and established new priorities for the future.

The three main themes all related to a process theme. This theme expressed the dynamic nature of healing and is represented in each of the substantive themes. There were some specific comments by participants that related directly to the process of healing and these will be discussed in a separate section following the three main themes. To clarify these relationships, Figure 1 depicts the three main themes and the process theme in diagram form.

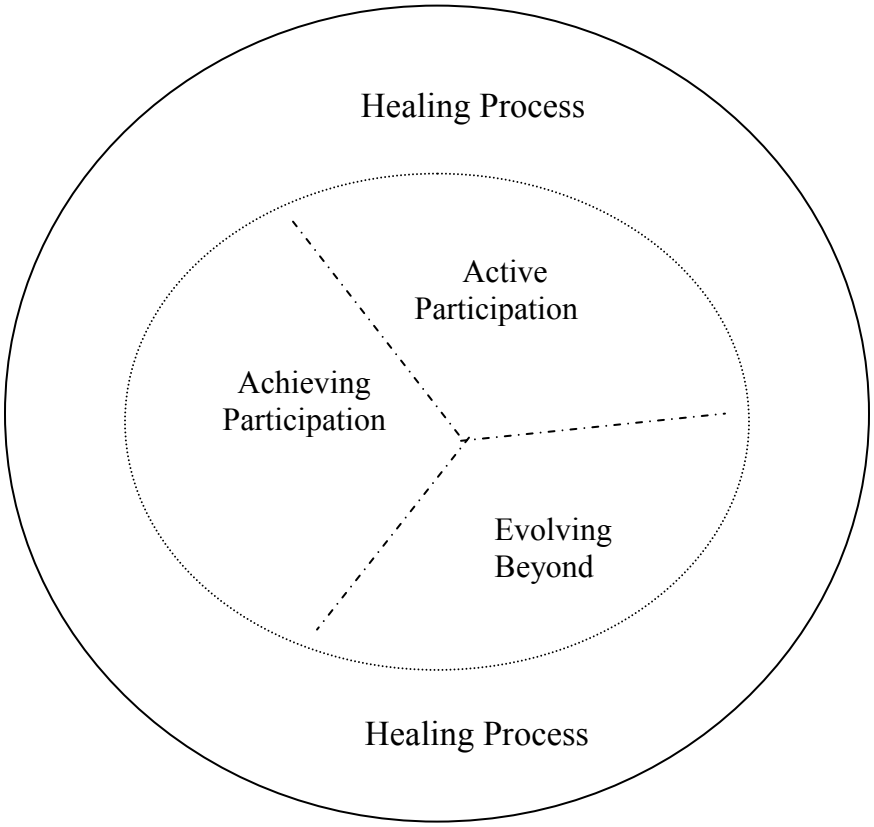

Figure 1. Healing Themes.

The three major themes and the process theme were supported by subthemes. These relationships are expressed in Table 5.

Table 5

Themes and Subthemes

Themes	**Subthemes**
Active Participation	The Goal is Control Healing is a Private Experience Emphasis on Uniqueness Attitude Heals
Achieving Balance	Mind-Body Incongruence Overdoing and Underdoing
Evolving Beyond	Life Review and Self-Examination Purpose Test of Expectations Spiritual Meaning
Healing Process	Beyond the Wound Toward Healing as Part of Life Emotional Change Healing Milestones Temporality

Active Participation

Surgery is a profound event that temporarily robs individuals of a sense of control over their lives and their bodies. These participants actively sought to regain that control. They felt personally responsible for their healing process and actively participated in making it happen. They were proud of themselves if they were doing well or upset with themselves when they had setbacks. As they believed their attitude was essential to

healing, they actively worked on making it positive. They pushed other people away for a time in order to heal in their own way. They wanted to know and understand what to expect and were anxious to get started on whatever they were allowed to do. That is not to say they did not make use of medical resources and assistance from others. They usually accepted their need for help but actively sought to reduce that need.

The Goal is Control

A specific desire to take conscious control was expressed by all participants. They were frequently proud of themselves for how well they were doing or upset with themselves for how poorly they were doing. They thought that they had control and that the success or failure of their healing was at least partially up to them. All the participants talked about the importance of gaining or maintaining control. Most participants were successful in this pursuit and they considered this success important for healing.

Healing is a Private Experience

Another part of Active Participation was the view that healing was a private, personal experience. People, events and environmental conditions were experienced as relevant to healing, but each individual seemed to want to direct the process of their healing in their own way.

Friends and family were appreciated for their support, but at a distance. It was nice to know they were out there sending cards, calling and praying for them, but each participant seemed to want to do what was necessary on their own and in their own way.

All the participants had some thoughts about the privacy of this experience. Outside influences were not dismissed as irrelevant to healing, but there was a very strong desire to do it themselves and not to have requirements put on them from the outside.

Emphasis on Uniqueness

Another theme related to Active Participation was a realization of each participant that they and their healing were unique. It seemed the participants did not want to be categorized with other people. Each person seemed to acknowledge that no matter how many people had come before them, this was a unique experience, different form all others. They could learn from other people's experiences but they wanted to be recognized as unique.

Attitude Heals

By far the most persistent idea expressed by the participants was that the nature of one's attitude was essential to healing. The most common realization was that one's attitude must be positive for a positive healing outcome.

Attitudes that were defined as positive included: determination, acceptance, patience, hope, and optimism. Attitudes thought to be negative and therefore detrimental to healing included blame, feeling sorry for oneself, discouragement, and resignation.

Attitude was considered to be a part of healing over which the participant could exercise some control. All the participants believed a positive attitude was important in healing and many of them worked to achieve this attitude. Changing from a negative to a

positive was difficult at times, but participants who found themselves thinking negatively attempted to make this change.

Achieving Balance

The second theme was Achieving Balance. Participants described their mind and body as dichotomous with each part healing at a different rate. They wanted to integrate these "parts." Many participants struggled to achieve a balance between overdoing and under doing. Balance was also reflected in a struggle with dependence and independence, control and un-control, imagining progress and accepting limitations, and gaining a positive attitude versus focusing upon doubts and fears.

Mind-Body Incongruence

All participants spoke of a connection between their minds and their bodies. For many participants this connection was experienced as being out of balance during this healing experience. The mind and the body healed at different rates or were perceived as going in different directions. Immediately following the surgery both the mind and the body were unable or unwilling to do much beyond resting and sleeping. Often either the mind or the body was ready to increase its functioning at different time than the other. So, the mind could be ready to go out and to do things before the body was ready to cooperate or the body could feel great but the mental strain of work could still be too much.

The balance between the mind and the body is closely connected with Active Participation. Participants acknowledged that they actively restored their balance through

their attitude, accurate reading of messages from the body, maintenance of physical health, and being sensitive to signs of imbalance.

Overdoing and Underdoing

How does one tell whether one is overdoing or not doing enough to facilitate healing? This was a dilemma for many participants since they assumed that they could indeed influence healing and it was important to find the balance.

Achieving balance was a major goal. Participants wanted to push themselves enough to facilitate healing and yet not so much that they caused a setback, thus slowing the process. "Overdoing" often appeared to result from an intense desire to do something to enhance the healing process. When this desire was frustrated the individual was more likely to disrupt the balance by becoming tense.

Evolving Beyond

The third major theme of healing was the process of evolving beyond the specific recovery from this surgery. Participants sought meaning from their experience. They often reviewed past decisions and examined their lifestyle and values. They contemplated changing goals and priorities. The experience expanded beyond healing form this specific surgery into a process of life healing.

Healing Process

The substantive themes do not have clear boundaries. This overlap is important as an attempt has been made to retain the integrity of the data as a whole. If a

phenomenon is unitary, its parts will have independent characteristics and some overlap. For example, Achieving Balance and Evolving Beyond both imply participation on the part of the person healing and therefore relate to the Active Participation theme. The participants recognized the dynamic nature of healing and attempted to describe what they had experienced related to the process.

Healing is a complex process that is often referred to as if it was understood, yet little has been done to explore its properties. This foundational research was conducted to provide a basis on which to build further research about healing. Although the results of this study are not generalizable, they do provide direction for healing research. The results have also demonstrated some linkages between bodies of existing research that have not been clearly connected to healing before this study. The ideas found in the literature are often theoretical or clinical, and thus need further research to strengthen their credibility. The results of this study help to achieve this end. These results combined with theoretical ideas can also lead to clearer research questions and stronger hypotheses for future empirical study.

Results and Findings

In the process of reviewing the literature it was found that the model of healing was not supported entirely. Some of the healing conceptualizations found in Chapter One did come close to a generalized version of participants' conceptualizations but not to the specific patterns found in the data.

Participants had their own conceptualization of healing as evidenced by their unhesitant ability to use the word and their ability to thoroughly discuss the concept. As

discussed in Chapter One, the word healing is not used in the majority of the nursing or medical literature except as a physical process. Comparison of the participants' conceptualizations with the extrapolated conceptualizations of nursing and medicine revealed participants having a view closer to the conceptualization by nurses. They did not focus on the injury, the incision or the surgical repair as medicine might. At times they insisted that they did not consider themselves ill. Their conceptualization of healing included physical, emotional, spiritual, interpersonal, historical, and environmental issues.

As nurses view their approach to be holistic it follows that the holistic conceptualization of healing would also have similarities to the participants' descriptions. In the holistic conceptualization, found in Chapter One, it was discussed that the goal of healing is to restore the dynamic balance between mind, body and spirit. The participants related to this idea in the theme of Achieving Balance. The holistic conceptualization also included restoring a sense of connectedness to the universe. Participants described this in "returning to the world" that was one phase of the "stages of healing" as depicted in Figure 2.

Phenomenology, as a guiding framework for this study, is integral to a holistic perspective. A basic assumption of phenomenology is that phenomena can be examined holistically. Every effort was made to allow the participants to include all issues relevant to the experience of healing and to examine their experience in a holistic framework.

The literature reviewed was often found to relate to parts of the data. Each theme will be explored to demonstrate the congruencies and discrepancies with this literature.

Active participation

Active Participation had a focus of self-healing. The role of doctors and other health professionals, family, friends and God were included. However, participants realized that there were physiological processes over which they had no conscious control. They did understand that they had a major responsibility to heal themselves.

Self-healing is stressed by Jaffe (1990) and Albright & Albright (1990). In both papers, techniques to enhance healing are discussed. These include biofeedback, imagery and relaxation. The focus is neither on natural self-healing styles nor on what individuals do to help their own healing, but on what practitioners believe to be useful to enhance healing.

Nurse theorists such as Parse (1981) and Omery (2003) discuss active participation, by the individuals, in the healing process. Parse states that individuals are responsible for their personal health through reflective and pre-reflective choosing. She sees humans as "co-creating" health by participating with the environment. Omery considers self-care as the central goal of nurse-patient contact. Self-care includes practices and activities that are initiated and performed by an individual to maintain their own life, health, and well-being. The nurse intervenes only when self-care is not possible and returns the responsibility for self-care back to the individual in whatever way it is possible and as soon as it is possible. Omery (2003) and others have refined this theory making it concrete for practice and research. For example, ten "power components" have been defined, identifying such self-care issues as: decision-making about self-care; ordering discrete self-care actions; and integrating self-care operations with other aspects of living (Gast et al., 1999). Narayan and Joslin (1990), in describing the components of

holistic health, see nurses as the facilitator of healing, but that the responsibility for one's health rests within the individual.

Wood (1989) discusses the self-care literature in general and expresses a concern that it is assumed that helping oneself is beneficial. She examines self-care in relation to models of illness behavior, health behavior, and health promotion, and notes that none of them include health as an outcome. She contends that obtaining evidence that self-care has a beneficial effect on health should be a high priority for future research. The participants in this study came to conclusion that self-care was beneficial, but this is an important question for further study.

Another important aspect of Active Participation was the desire to regain control. According to Bandura (1999), the belief of individuals that they can exercise control over events that affect their lives, is very important to human beings. This includes an ability to exercise control over one's thoughts, motivation and action. Bandura states that people vary in their conviction and they will be able to exercise control over potential threats. When the threat occurs, people who show more conviction that they will be able to exercise control and show fewer stress responses.

A sense of being in control was part of the Active Participatory process for the participants of this study. According to Bandura et al. (1995), feeling out of control increases stress responses, including physiological changes that potentially could affect healing. Feeling out of control also affects psychological well-being which these participants describe as part of healing. Seeman and Seeman (1993) find that people who feel a low sense of control had less optimism about their health, more illness episodes, longer bed confinements when ill, and more dependence on their physicians.

Control was a struggle for many participants. During the surgery and very early recovery they could usually relinquish this control. In his study, Moch (1998) describes a control/uncontrol balance.

In another study by Taylor (1993), two-thirds of the 78 subjects acknowledged that they had at least some control over course and recurrence of their cancer, and 37% saw themselves having "a lot of control." They, like the participants in this study, acknowledged that they actively participated in the healing process. Smith (1996) found that 89% of 44 medical-surgical subjects seemed surprised when the researcher asked them what they did to help themselves recover. This was during their hospital stay and perhaps too early for them to be feeling a need to regain control or take charge of their healing.

Another aspect of Active Participation that can be examined in light of the literature is the desire for privacy. Before the data were reexamined in light of the follow-up interviews, the privacy of the healing experience was a puzzle as it seemed to contradict the notion that social support has an important affect on health outcomes and also acts as a buffer to stress, thus improving mental and physical health (Broadhead et al., 1993). Although these participants tried to gain privacy, sometimes rejecting social contacts, all but one of them had strong social networks on which to rely, so they did not feel a deficit in this area. Had they not had strong social ties, their desire for privacy may have been different.

The desire for privacy could also be a reflection of the desire to restore the privacy of those things that were private before surgery during illness, especially when hospitalization is involved; privacy is often relinquished in such areas as eating, bowel

habits, and exposure of parts of the body not usually exposed. These losses of privacy could be uncomfortable enough that people may temporarily revert to the opposite extreme, insisting on privacy beyond their typical level. This insistence on privacy may be a transitional state related to achieving balance.

The desire for privacy seemed to represent a phase related to regaining independence and control. Later, when participants were re-contacted, it was discovered that they again allowed close contact, at times even closer contact, than they had prior to surgical experience. They did not want to share their stories about these experiences; rather they wanted to enjoy the comradeship between themselves and others who had been through similar experiences. They also enjoyed people in general and their relationship to them was closer than they ever had.

Smith (1996) found a high level of acceptance of the loss of privacy during the hospital stay. This could lend more credence to the idea that the need for privacy is transitional. Perhaps, the phases are: acceptance of reduced privacy → active regaining privacy → restoring the privacy balance.

The need for a positive attitude and optimum for healing was by far the most frequently mentioned subtheme. Participants discussed positive attitudes as a part of healing, that is, healing from surgery included mental or attitudinal improvement. They also described it as necessary for and connected to physical healing. They were not certain about how this connection occurred, but they acknowledged it existed.

Taylor (1993) also found that one of the most common beliefs of her subjects was that a positive attitude would prevent their breast cancer from returning. Levy, Lee, Bagley and Lippman (1998) discovered a relationship between positive mood and living

longer with breast cancer, and similar results with joy and living longer with breast cancer. As has been mentioned previously living longer is not necessarily, but this research may add to the strength of the importance of positive attitudes.

Cognitive psychologists have demonstrated that attitude affects emotional responses (Beck, 2006). There is some evidence that a realistic set of attitudes, as opposed to negative attitudes, reduces physiological stress responses (Eiser, 1990). It is very possible that the reduction of stress responses such as lower blood pressure, reduced cortisol release, DNA repair, and increased natural killer cells, would enhance healing. Most likely, there are other physiological changes not yet discovered that relate to attitude and healing.

Hardiness has been correlated with positive health outcomes having characteristics of commitment (enthusiastic involvement in life); control (a belief in one's influence over life events). Each of these characteristics relate to positive attitudes.

Some participants have found optimism to be one type of positive attitude. Scheier and Carver (1996) develop a tool to measure "dispositional optimism." This is the general understanding that good rather than bad things happen to them. As has been discussed in Chapter Two, this optimism appears to have a relationship to positive health outcomes. It has been shown that optimism leads to increased persistence, greater self-esteem and lower anxiety (Scheier & Carver, 1996). Tennen and Afflect (1997) express a concern that since positive outcomes do not always occur, optimists may be more vulnerable to disappointment and anxiety when things go wrong. Perloff (1993) argues that optimists are more able to go about every day activities without being continually "on guard" with tension about what might happen. Cognitive psychologists state that

there is a middle ground that is more related to mental health. The middle ground is a realistic appraisal that tends to yield a confidence in one's ability to cope, and a recognition and acceptance that difficult situation often do arise (Eiser, 1990).

It is difficult to differentiate between "putting on a happy face" and firmly believed optimism. Cognitive Consistency Theory would argue that positive verbalizations, regardless of whether they are believed, would help reduce tension and improve health outcomes (Joule, 1993). However, "putting on a happy face" could be considered a type of repression and there is some evidence that repression leads to negative health outcomes. Cox and Mackay (1992) conclude that inability to express emotion is a significant risk factor in relation to cancer progression. Jensen (1997) discusses that repressors (as measured by the Marlowe-Crowne Social Desirability Scale and the Short Form Taylor Manifest Anxiety Scale) are more likely to be found among subjects with a history of cancer than those in the healthy control group. Repressors are also more likely to be in the group where the cancer had advanced than were it had not, and the repressive personality style is also correlated with significantly shorter remissions.

Depression can be considered the opposite of a "positive attitude," as one of its predominant features is negative evaluation of events and people. Depression has been found to have a negative effect on health-related factors. Kiecolt-Glaser et al. (1994) find depressed subject to have significantly poorer DNA repair than does subject who is not depressed (measured by the Minnesota Multiphasic Personality Inventory, Scale 2, Depression).

Inherent in Kobasa's et al. (1999) Hardiness Scale, discussed in Chapter Two, is the expectation of optimistic cognitive appraisals in hardly individuals. Kobasa et al. has also found hardy individuals to be healthier (as measured by the Seriousness of illness Survey and a self-report symptoms checklist). An intuitive leap, unfounded by research, would say that these individuals would also tend to heal better. Further research is needed in this area.

The issue of control is also at least partially attitudinal. Participants struggle to regain control of their lives, and they expected to be able to gain control of their attitudes. With the belief that they were responsible for their attitudes the participants could be very self-blaming if their attitudes were not positive. Often they recognized when they were frustrated about their poor attitudes, and that this frustration was a poor attitude in itself. Once this layering of frustration about frustration began it was difficult to stop the process. The downward spiral ended when positive events occurred to break the pattern. The same effect, in reverse, also seemed to occur. At least three participants had a positive attitude about having a positive attitude.

Another part of Active Participation was the desire by participants to know what to expect. They disliked having more pain or tiredness than expected. They wanted to know when they could exercise, when they could return to normal functioning and what problems they might encounter.

Tiredness was a significant area of concern for many participants. Some people who had experienced it during prior surgical experiences, and one person who had been warned to expect tiredness, had less difficulty. Also, those who were not suddenly thrust into their full range of responsibilities had less trouble. Webb and Wilson-Barnett (1993),

in one of the few studies that contacted subjects after their hospital stay, found tiredness to be most common complaint after a hysterectomy. This was unexpected to these subjects as it was to the participants of this study. Tiredness was confusing, apparently because it was unexpected and hard to define, justify or visualize. Other people could not see it and they often expected a greater capacity to function than the participant could manage.

Participants expressed a strong preference for accurate information in other areas. If the participant's information was incorrect, incomplete or non-existent, frustrations developed. Frustrations contributed to a negative attitude which the participants considered to be detrimental to healing. Having accurate information contributed to a sense of control and helped participants avoid emotional upset. Prior surgical experience seemed to help by providing a sense of knowledge about what to expect. McFarlane, Norman, Steiner, Roy and Scot (1990) in a longitudinal study involving 500 subjects asked why people do not uniformly become ill after exposure to stressors of similar magnitudes. The results indicate if subjects lack a sense of control or do not have an opportunity to anticipate the stress that there is a greater chance of having more illness symptoms.

Accurate anticipation has some similarities to one of the central axioms of Martha Rogers' conceptual model. The idea of participating knowingly includes being aware of what one can do, and with that knowledge making choices freely and intentionally (Barrett, 1996). These participants wanted information with which they could make choices. They expressed a belief that they were equipped to freely choose what was in their own best interest in relation to many aspects of healing.

Bandura (1999) discusses forethought as often regulating human behavior. He observed that people left unsafe and more highly stressed if they were deprived of the ability to plan for their actions. They could extrapolate future consequences from known facts. They were then able to take action to avert negative consequences. Helena and Annie both planned constructive actions in light of information from their prior surgeries. Ivani would have liked more information to have avoided returning to work unprepared for the inability to do his job. Moch (1998), in discussing the "crisis of physical illness" (p. 7) defines one of the important coping skills as seeking relevant information, so this information might relieve anxiety caused by uncertainty and misconceptions. Rehearsing alternate outcomes is another suggested coping skill. It is thought that anticipating outcomes reduce stress by reducing the number of unexpected problems.

Although there are no strong evidence for certain personality characteristics being more or less amenable to healing, Simonton and Matthews-Simonton's (1994) clinical observations of survivors of cancer were compared to the results of this study. These "survivors" were found to be: rarely docile; were non-conformists; had permissive morality; and had an appreciation of diversity. Several of these characteristics relate to Active Participation since they describe someone who would not passively allow healing to happen, but would be involved in whatever was happening in their life. The possible effects of an optimal attitude, a desire for control, and a certain amount of independence were noted earlier. These are all similar to the traits of the "survivors."

Physical care is a more obvious area where one can actively participate in healing. The participants focused less on this area, but they did realize that exercise and nutrition were important for general health and therefore for healing. Some paid particular

attention to exercise and nutrition for faster recovery. Those who required exercise to regain functioning after their particular surgery were eager to begin as quickly as possible. For example, Michelsen and Askanzi (1996) discuss the importance of nutrition during stress and injury. Schumann (1999) describes the specific nutritional needs to promote wound healing after surgery. She also discusses the importance of overall health in post-operative recovery.

Kobasa, Maddi, Puccetti and Zola (1992) report exercise to be associated with lower overall illness scores in executives under stress.

Active Participation is supported in relation to health if not to healing by literature in the areas of control, attitude, and physical care. It is also supported theoretically as a concept, by literature related to self-healing and self-care. It appears that social support needs to vary as healing progresses and this idea is not addressed in the literature. At this point the connections are fragmented, but have promised to support the existence of the Active Participation theme. With the exception of privacy needs and social support issues, no literature could be found that contradicted this theme.

Achieving Balance

Achieving Balance was discussed most frequently in terms of overdoing and under doing and the mind-body connection. Participants touched on balance with issues such as dependence-independence, time allocation between work and play, social and private time, and exercise and relaxation. There was also more subtle undercurrent that is difficult to describe. They wanted to get back to "normal" where they no longer were so

consciously aware of their functioning and were not so out of touch with the mainstream of life; to gain an overall "life balance."

Nurses' deal with the issue of balance as it is conceptualized in this model. Beuman's Systems Model describes organisms in a process of homeostasis with an ongoing play between balance and imbalance and equilibrium (Newman, 1996). Rogers (2001) would not use the word balance because of its static nature, but her concept of homeodynamics is in some ways similar to these participants' descriptions. Their balance is not static, but changing and like Rogers could be describing movement along a spiraling axis with rhythms and patterns.

Dossey (1994) describes the Zen Buddhist idea of balance and applies it to health. Opposites are always represented in the whole. Beauty-ugliness, static-dead, intuition-reason, and health-illness are examples. He describes Western man as often attempting to eliminate one side of the pair. Reason is emphasized while intuition is ignored. Reason is used to attempt to eliminate illness in order to arrive at a state of health. According to Dossey (1994), a Buddhist would not try to figure out how to be healthy. He would accept that he is health, but he also is illness since one cannot exist without the other. These participants represent a "Western" view because of their active involvement in trying to restore health and eliminate one side of other dichotomous pairs. The participants did recognize that there could be an ideal place between many pairs and sought to find the balance (for example, overdoing, underdoing).

The connection between mind and body seemed important, but difficult to articulate for many participants. In their description of the mind, they included spiritual, emotional and cognitive aspects. The body included internal and external physical

changes. Some concepts such as tiredness were sometimes related to the mind and sometimes the body. One of the early outcomes of surgery was disconnectedness within the mind-body relationship. The balance was somehow disturbed. Participants attempted to take conscious control of something that was usually automatic. Healing felt to them like it occurred at different rates in the mind and the body. The mind became impatient and the body was not ready to respond. At times the opposite was true with the body seeming ready to function normally and the mind having difficulty. However, the mind and the body were not necessarily seen as totally separate.

It does not seem unusual that these participants had difficulty describing the mind-body connection. It is a phenomenon that has been grappled with for hundreds of years. Philosophers such as Gallagher (1986) have discussed the "lived body" as being a non-conscious experience until it loses its equilibrium through pain, fatigue, injury, distortion or embarrassment. The "lived body" then becomes the central focus.

When the body cannot do what is desired, it becomes an obstacle to be overcome rather than a connected whole. Gallagher (1986) proposes that these times of acute awareness of the body may be the basis for mind-body dualism.

Merleau-Ponty (2002) views the conscious and preconscious mind and the material body as not separate. The "subject" is the center of meaning and wholeness always. The "conscious I" may feel disconnected, but the "natural I" or preconscious is always aware of the true connection of the mind and body in the context of the world. Similarly, when Frank (1993) discusses Shamanistic healing, he states that the mind, body, and spirit do not need to be rejoined, but only the awareness of wholeness needs to be restored.

Increasingly, physical evidence exists to support the participant's notion that the mind and body are connected. Psychoneuroimmunology is the study of the physiological connection between the mind and the body. Emotions, neurological responses, and immune responses have all been demonstrated to have chemical connections (Levy, 1998). Along with being important in supporting the mind-body connection, this growing body of knowledge adds credence to the participants' idea that emotions and attitude can influence healing.

Nurse theorists have commented on the mind-body issue. Newman (1996) describes the mind and body as manifestations of some larger reality. One does not cause or control the other. Some of the participants in this study struggled with mind over matter and felt disconnected while this struggle was occurring. Other nurse theorists such as Rogers (2001), Fitzpatrick (1999) and Parse (1981) define man as an irreducible whole with mind-body dualism being non-existent. Participants felt disconnected but their preferred state was having a sense of wholeness.

Holistic medicine is one of the few spheres of medicine that uses the word "healing" in a broader sense (Otto & Knight, 2001). Traditional medicine tends to focus on a specific disease while holistic medicine attempts to examine whole person in the context of their environment. Participants tended to describe their healing holistically. They rarely discussed the incision, and physical aspects of recovery were minimized. Healing was seen as a much more complex relationship between physical, emotional, spiritual, interpersonal, personality and environmental aspects. Being "out of balance" was uncomfortable and thus returning to a state of wholeness or balance seemed important to all of the participants.

The balance between pushing oneself too hard and not doing enough was an issue for the most participants. In the researcher's clinical experience this is often a necessary adjustment after recovery from many emotional or physical difficulties. What is normally automatic cannot be relied upon as such, since normal functioning is impaired. Fatigue indicates that it is time to slow down or stop, but if one gives in to the fatigue some individuals fear improvement might be slowed. However, if one pushes too far despite the fatigue, a setback can occur that may last for days. It is often difficult for anyone to establish what is too much or too little, so one's internal awareness is important.

Underwood (2001) in refining the self-care model proposes five basic universal self-care needs. Two of these needs include issues of balance, that is, balance solitude and social interaction and, similar to the issue of overdoing and underdoing, a balance between activity and rest.

Moch (1998) objects to the necessity of always helping people gain control when in fact acceptance of the "control/uncontrol balance" may be a more useful objective. With this acceptance it is easier to asses how much control is realistic and what control is not attainable at a given point. Almost all the participants in this study accepted their lack of control and lack of independence during their hospitalization. In general, participants did not like the reduction in control or independence, but they found it inevitable. Early dependence was tolerable but acceptance of this dependence was time-limited. Perhaps this lack of acceptance is essential in the initial phase of regaining the control. Recognition of both the need to regain control and the tendency to overdo could enhance the process of Achieving Balance.

Achieving Balance has some theoretical and philosophical support, but no research was found that clearly related to this process.

Evolving Beyond

Finding meaning in illness through values clarification, new learning, strengthening growth that had already begun, or reviewing past decisions and beliefs had some similarities to Moch's (1998) theory of health within illness. She describes "illness as an opportunity for health" (p. 24). She discusses that examples of ways one might demonstrate health within illness are: feeling closer to family; finding inner peace; experiencing greater spiritual dimensions; feeling a greater aliveness and connectedness with the whole; learning about one's self; and having the opportunity to reflect on the meaningfulness of life. The concepts relate very closely to the theme of Evolving Beyond.

Many of the major nursing theories discuss the idea of growing through illness. Rogers (2001) describes man as continuously changing from lower to higher frequency wave patterns with increasingly diversity. This way of conceptualizing man attempts to depict man in constant process from lower functioning to higher functioning. The movement is always toward great diversity. In other words, man is always evolving. These changes are occurring in health or illness. Fitzpatrick (1999) views health as continuously developing, so as awareness. Like Rogers (2001), Fitzpatrick describes man as evolving continuously and irreversibly whether sick or well. Newman (1996) considers illness as a manifestation of the total pattern of the individual and therefore an aspect of health. Travelbee (1996) identifies illness as an opportunity to find meaning

and to move to a higher level of functioning. She sees illness and suffering as part of life and growth experiences. Parse (1981) considers health, among other things, as choosing lived values. Like Rogers (2001), she describes man as continuously growing toward greater complexity and that health is possible during illness. Chick and Meleis (1996) discuss illness as a transition with a chance of experiencing a new beginning. In identifying four models of human health, Smith (1996) labels the most complex model Eudemonistic. Health in this model is a process of actualizing or realizing one's potential. Illness could impede or prevent self-actualization. Further clarifying, Smith (1996) defines actualization as continues growth through new experiences. This would imply growth and therefore health is possible through any experiences including illness.

Other theorists have been discussed in Chapter Two under "meaning through illness." Dossey (1994), Siegel (1996), and Jaffe (1990) all state that there is a potential for self-renewal and greater understanding after illness. Jaffe (1990) describes self-renewal as a rare response by special people. As all the participants in this study experienced some self-renewal, these results contradict Jaffe's (1990) hypothesis that this is a rare response. Narayan and Joslin (1990) and Aguilera (1996) state that the crisis of illness is an opportunity for growth.

Evolving Beyond was often supported in general, but no literature was found to support specific subthemes such as "test of expectations" and "purpose." The conceptualization of spiritual healing as described in Chapter One includes ideas about the meaning of illness, as well as an awareness of the greater meaning of life. Evolving Beyond included these ideas. Participants discussed their own spirituality, but it did not usually change as a result of this experiences as was thought to happen in the spiritual

healing conceptualization. The participants who were aware of their spiritual views used these ideas to clarify the meaning of this healing experiencing.

Theoretical frameworks consistent with the theme of Evolving Beyond plentifully. However, research supporting these theories is limited. Taylor (1993) found that over 50% of the 78 women with breast cancer interviewed in her study reappraised their lives and priorities. Smith (1996) asked specifically for ways in which participants' values, goals and priorities had changed. She interviewed 44 medical-surgical patients with illnesses ranging from myocardial infarctions to radical mastectomies, 31 psychiatric patients, and 11 alcoholic patients. All participants were still hospitalized at the time of their 45-minutes structured interview. A "few" (an unspecified number) were interviewed a second time after hospital discharge. Sixty-six percent of her medical-surgical patients answered quickly with feeling about change in values and priorities. This gain contradicts Jaffe's (1990) conclusion that only special people experience renewal. Their most frequent area of desired change was similar to the participants of this study who expressed time with family. Psychiatric and alcoholic patients also expressed changes in values and priorities, but their most common expression was a need to put more values on themselves. Smith (1996) is vague about how she collected and analyzed her data or how she chose her subjects. Her results do have similarities to the idea of Evolving Beyond. Since her participants were all in the hospital at the time of their interviews this would indicate that Evolving Beyond may start early in the healing process. In later interviews, Annie and Erikate indicated that some of the resolve to change had faded.

Evolving Beyond is perhaps the most exciting of the Healing Themes as potential for growth is very appealing to this author and it appears to appeal to many theorists as well. None of the participants experienced a setback in level of functioning. Rogers (2001) would say setbacks are not possible since man is continually evolving to higher levels. Aguilera and Messick (1996) recognize growth through crisis as desirable and possible but returning to pre-crisis levels is also possible, as is a reduction in functioning and well-being. Whether Evolving Beyond is inherent in the healing process is an important question. Can there be healing if one has returned to a pre-surgical level or regressed?

Healing Process

One of the auditor's comments suggested that the results section should be introduced by the Healing Process theme rather than the substantive themes. She was correct in wanting to define the importance of process in a lived experience such as healing, but one must also consider that the specific subthemes discussed under process were not as important as the process incorporated in each substantive theme. The researcher agreed that the healing process is very important, but undue emphasis would be placed on the process subthemes if the Healing Process were discussed before the substantive themes. This discussion will focus on process as it is addressed specifically by the data and process as it is woven into the fabric of the substantive themes.

"Process is a dynamic term denoting change" (Rogers, 2001, p. 57). Change is the central feature of process, but it is important to note that this does not mean strictly linear change. Change is inherent in relationships (Brennan, 1988). Every interaction

between variables affects some change in each of the interacting variables which may in turn interact with one another broadening the circle of change. Healing can be conceptualized as a process from illness to health, but this oversimplifies the amount of change that healing represents. Brennan (1988) uses an example that illustrates some of the complexity of this process. The condition, diabetes, has particular functional deficits, but the process of this condition varies widely. Psychological stress can increase the need for insulin and this stress can be caused by fears generated by being identified as diabetic and having fears related to prior knowledge about the condition. To carry the example further, lack of knowledge could also contribute to stress, perhaps with a fear of loss of control. An increased need for insulin could relate to a variety of stresses mediated by the personal interpretation of these stresses. Stress is only one of the many variables that interact with a sickness or healing process.

Human existence always includes involvement in the world (Collaizzi, 1998). Interaction with the complex world is inevitable and with interaction there is change. Human existence implies process.

Traditional research often misses the process element of human existence since this element does not easily lend itself to statistical analysis. In recent years, methods such as phenomenology have been used to attempt to understand processes. Before this study the healing process had not been explored. Therefore, there is little in the literature that specifically addresses process in healing.

It might be useful to examine a statement introducing the findings of this study. "The experience of healing as experienced by these nine participants was an active, involving process with movement toward achieving balance and wholeness and the

individuals evolving beyond the place they started prior to surgery." This statement captures the experience of healing and is clearly a statement of process.

A Model of Healing

The themes generated by this study can be viewed more abstractedly in proposing a model of healing. The model includes three substantive themes: Active Participation; Achieving Balance; and Evolving Beyond. These themes connect with one another in a very fluid way. The diagram from page 81 has been reproduced here to facilitate discussion (see Figure 2). In conceptualizing the relationships among these themes, each one can be described as simultaneously integrated, yet distinct. The broken lines on the diagram represent the integration. This connection among themes is important since an attempt was made to retain the integrity of the whole experience of healing, yet to have enough defining characteristics to begin to understand the concept.

The Healing Process component of the model has a different quality than the three substantive themes. It is very much an integral part of all the themes and even more difficult to discuss as separate than each of the other themes. The substantive themes define healing while the Healing Process addresses movement and change. Process components are found in each of the substantive themes but are not the identifying characteristics of these themes.

When a concept is explored using phenomenology, an attempt is made to retain the integrity of the whole, describe complex relationships with one another. None have clear boundaries and they all relate to one another as a whole process of healing and yet each can be defined separately. There is movement and change in all four themes.

Active involvement is included in all four themes. Both Achieving Balance and Active Participation are evolving experiences. Achieving Balance and restoring a sense of wholeness is one aim of Active Participation and Evolving Beyond. The relationships among the healing themes have been described in a way to illustrate their complexity and retain the sense of wholeness. The process theme helps integrating the whole and helps accounting for change and movement (see Figure 2).

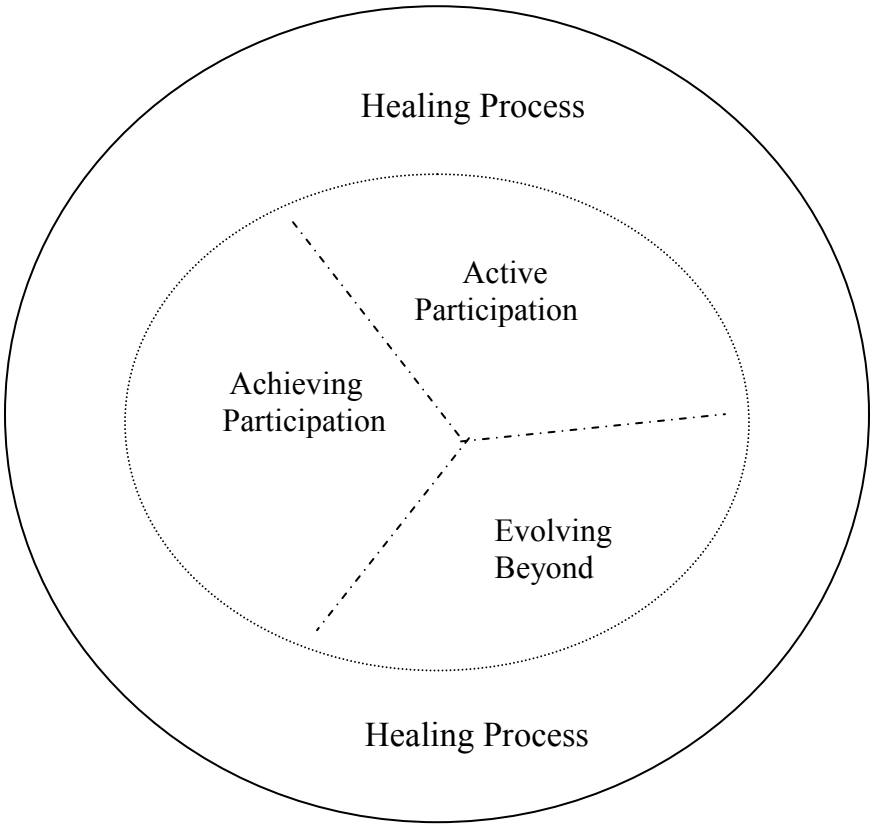

Figure 2. Model of Healing.

It was not asked whether healing exists or whether the participants' perceptions of healing were correct. In phenomenology, the focus is on perceptions, so participants are not asked to justify the accuracy of these perceptions. Colaizzi (1998) suggests that a

researcher should expect blind spots and obscurities that no participant will be able to articulate. Some areas about healing may never be understood, but many can be addressed by defining areas for further research to expand and clarify the model.

In explicating the model, Active Participation includes an active part as important for healing and it also includes the actions demonstrating these insights. Regaining control is one of the central features of this element of the model. When surgery occurs, the perception that one is in control is temporarily lost and involvement in the return to health may help to restore a sense of control. It is possible that surgery or illness is a reminder of how fragile one's control actually is, motivating a desire to do something to recreate an illusion of control. It seems, however, that the participants realized that there was much more to Active Participation than a need for control, whether illusion or real. It was freely acknowledged that there were parts of healing over which no conscious control was possible. There was a desire to restoring control, but there was also a desire to enhance healing. It was thought that optimal healing could be influenced. It was also possible to impede progress, usually inadvertently. It was considered that the responsibility of the person in the process of healing to monitor mood, attitude, and activity level to intervene when it was discovered that a problem was developing.

Achieving Balance was often an active process, but it had sufficient differences from Active Participation to be considered a separate theme. Balance seems to be described by the participants as the place between two dichotomous extremes where maximum functioning occurs. In this case, maximum healing can occur if a balance is reached between overdoing and underdoing, control and uncontrol, dependence and independence, progress and limitations, and hopes and doubts.

This balance is not a static point, but is constantly changing. For example, one needs to be dependent early in the healing process, but this need for assistance changes rapidly, usually with a steady reduction in the need. Setbacks are possible so the need to be dependent can return unexpectedly, necessitating another adjustment. It is complicated to find the place of balance at each new level of recovery and some conscious awareness is necessary until a state is achieved that will become the "normal" balance. It is also changing, but often in ways that can be left to unconscious processes. An example of this is if one were particularly tired he would naturally sleep a little longer then he normally would. Another example is one might allow oneself to be dependent in certain situations and very independent in others with the transition between the two occurring without conscious thought. Mind and body are another dichotomous pair of the balance, but they have a different quality since they are not extremes of a continuum. They are two "parts" of a human that are so highly integrated with one another that it seems difficult to divide them. They feel divided at times during healing and "the balance" is achieved when they return to an integrated state or sense of wholeness. The title chosen for the third substantive theme of the model was Evolving Beyond as this seemed to capture certain elements of the healing process that went beyond restoration of prior functioning. This part of healing includes self-awareness. A purpose, outside the person who is healing, such as being the primary caretaker for dependent children, influenced healing. Recognition of this purpose related to a greater self-awareness, but it was believed to have a more direct effect on healing. It was at once a comfort, i.e., "I do not need to worry about dying because my purpose will prevent that from happening," and a driving force, i.e., "I will heal quickly because I am needed." Evolving Beyond

often included examination of various aspects of one's life and motivation to make changes in lifestyle, emotional relationships or definitions of meaning. Prior to surgery, expectations existed about the surgery, but they also could be about one's ability to handle certain parts of one's life. The healing experience at times could be a test of whether certain beliefs are correct, i.e., "Does physical fitness help one heal faster or has one really becomes as independent as he hopes he has?" There is an exploration of meaning of this illness experience and an examination of the influence this experience might on the broader meaning of one's life.

A variety of life-disrupting events could initiate a similar experience to Evolving Beyond having surgery is a profound event which logically precipitates a time of pausing to reevaluate or take notice of one's life and choices. Although Evolving Beyond could happen in many life-disrupting events, it is important to healing since it cannot be separated from the healing experience and it influences and is influenced by healing. It seems possible that this dimension could also be present in less profound healing experiences. Many people can relate to an enhanced awareness of what it is to be well after a viral infection. There may be some resolve to get more sleep, take vitamins, or exercise, and some evaluation of the events that may have increased one's vulnerability.

Summary

This study found out that healing is a complex process that is often referred to as if it was understood, yet little has been done to explore its properties. This research was conducted to provide a basis on which to build further research about healing. Although the results of this study are not generalizable, they do provide direction for healing

research. The results have also demonstrated some linkages between bodies of existing research that have not been clearly connected to healing before this study. The ideas found in the literature are often theoretical or clinical, and thus need further research to strengthen their credibility. The results of this study may help to achieve this end. These results combined with theoretical ideas can also lead to clearer research questions and stronger hypotheses for future study.

CHAPTER FIVE

CONCLUSIONS, IMPLICATIONS AND RECOMMENDATIONS FOR FURTHER RESEARCH

Introduction

The Healing Process theme is more complex to discuss since there is more to the healing process than is discussed directly by the participants. The entire process theme was not strong with tangible evidence such as direct quotes about process, yet the flavor of process is constantly present throughout the data. A phenomenological study is intended to discover process. Although somewhat artificial to designate a separate process theme, a lived experience is process. Differentiating substantive themes and process themes serves a communication function with recognition that process is included throughout all themes. Active Participation includes change and a relationship between the body and the conscious mind. Achieving Balance requires a progression from a state of unbalance to a state of values and actions to a new and different state. Healing Process was differentiated only because distinct process issues did exist separate from the substantive themes.

The first process subtheme describes the progression of healing as moving from a physical focus, to a mental focus, to an integration of the event into one's life, and then a

return to the world. There is overlap in each of these stages, but the last two can happen almost simultaneously.

The second subtheme is a privacy progression, with the need for privacy greatly increased after returning home from the hospital. This need for privacy decreased in the months following surgery, until a new privacy balance was established. These privacy needs appeared to be a reaction to the loss of privacy during the hospitalization experience.

Emotional change occurred in three patterns: anxiety → elation → satisfaction →; anxiety → frustration → satisfaction; and anxiety → elation → frustration → satisfaction. Participants identified specific events that were healing milestones and they experienced some changes in their perception of time. These last two subthemes were not strong, but were included because they were part of the data.

It is unknown at this point whether the three substantive themes of healing and the process component are involved in more general healing experiences (i.e., different types of illness), whether they are prerequisites for healing to occur, whether an optimal healing process has these elements while an unsatisfactory healing process does not, or whether these elements have any relevance to different healing experiences, other than recovery from surgery. The literature was examined with these questions in mind.

Conclusions and Implications of the Findings

For research, healing as described by the participants is a complex process that is very difficult to operationalize. It would be useful to discover whether the experiences of these participants are similar to the experiences of a wider population of post-surgical

contingent (larger numbers, with differing socioeconomic status, culture and ages), as well as the experience of individuals recovering from other health imbalances. That is, do people who have chronic physical conditions, alcoholism or psychological problems have a similar healing experience to post-surgical individuals? This might be accomplished by doing a similar study with each of these groups or by interviewing members of each of these groups with more structured questions relating to the specific themes of this study.

As these results are compatible and at times very similar to theories related to healing and health, it would be appropriate to move on beyond basic research. A definition of healing could be operationalized and a "healing" scale could be developed. Once the tool was validated, comparisons could be made with concepts such as attitude scales, depression, hardiness, control, coping skills, and personality profiles.

Other questions relating to specific themes are:

- Are health professionals' views on healing similar to individuals' views?
- Does a sense of control in fact enhance healing? Or might it inference with or even retard healing?
- Do people who accept being out of control, when there is no alternative, have a better healing experience?
- Is there an optimal time in the healing process when control could be taken back by the individual?
- How can privacy needs be recognized? Are they actually relevant?
- What constitutes a positive healing attitude?
- Can health professionals help individuals to develop an attitude that

would enhance healing?

- Does how one handles tiredness actually affect healing process?
- Do different personality styles have different healing needs? Or healing styles?
- Does increased information enhance healing?
- Can personal growth from healing be enhanced?
- Does discussion or personal growth through healing enhance the growth process?

Is it possible that Achieving Balance could also be assisted by adopting a more holistic view? The consideration of multiple factors that may influence healing would be useful particularly if Achieving Balance is returning to a perceived state of wholeness. People could be taught to understand the integration of parts and the influence these parts have on the whole person, connected with and related to a complex world.

The person who is in a process of healing and their significant others might need assistance in dealing with the transition between dependence and independence. Both could be frustrated by a lack of understanding and acceptance of each other's needs. Nurses for instance, could be sensitized to these issues so that they could educate individuals involved with healing in hopes of preventing these frustrations from developing. If they do develop, communication about these problems could be encouraged to resolve these differences.

If there is an attitude conducive to healing, can individuals be trained or encouraged to develop this attitude? Assessment of depression, discouragement and negativity could be important. Cognitive restructuring may be useful tool in developing

healing attitudes. That is, Beck (2006) and Ellis (1977), among others, have developed tools aimed at changing cognitions (attitudes and beliefs) to more constructive, or in this case healing enhancing cognitions.

Might it be important to assess information deficits at various times in the healing process to help people gain the accurate anticipation that they may seem to desire? It seems important to not force information on people who do not want to hear it, so repeated assessments of just how much information a given individual feels comfortable with would be important.

Healing seems to be an opportune time for growth. Evolving Beyond happened naturally for the participants in this study, but is that usual? Could it be enhanced by clinicians discussing these issues with people who are healing?

For education, if this model of healing were found to be accurate it could be used in professional training to conceptualize the process of healing. The vagueness and lack of definition of the concept of healing has made it difficult to teach the multidimensional and integrative aspects of healing, but with this model as framework, understanding could be more easily transmitted. With a framework to guided instruction, students could be taught to address multiple healing issues, anticipate healing needs, and assess problematic healing.

In fact, nursing textbooks do not use the word "healing" except in describing wound healing, yet healing is central to nursing care. Although nurses strive to capture the holistic nature of human experience, focus on physiological issues such as wound healing often takes precedence. A holistic model such as this one may help to broaden that focus.

Recommendations for Further Research

Because of the lack of generalizability of the study, clinical implications must be approached with caution. A questioning of the clinical relevance of these results is appropriate to help to provide direction for further exploration of this model of healing.

If this model were to be found to be accurate, an assessment could be done with the individuals to determine their healing profile and to describe how they are managing each of the elements of healing. Could there be an optimal way to incorporate these elements into healing? With knowledge about this concept, individuals may be helped to avoid fluctuations from one extreme to the other. Individuals could be encouraged to attempt new activities, yet to observe carefully for signs of having done too much. Perhaps a person could be taught to avoid exhaustion. Recognition and understanding of dichotomous struggles such as dependence/independence, health/illness, or control/lack of control may also be useful to help individuals in achieving balance.

Moreover, attempts should be often made to represent holism by a compilation of numerous parts such as physical, emotional, spiritual, social, cultural, historical and environmental. The statement is made that the whole is more than the sum of the parts, but actually conceptualizing more than summing the parts is difficult. Models, such as this healing model, may help to bridge the gaps and foster a more complex understanding of holism.

Another recommendation is that, a nursing or curriculum in psychology that is focused on holism could have holistic healing as one of its core components. Watson (1998) states that the trend in medicine and nursing is moving away from "treatment and cure" and more towards "healing and caring." A curriculum with a focus on concepts

such as healing and caring that have been conceptualized holistically, could assist nursing students to attain an entirely new level of understanding of holistic health.

Summary

Generally, the findings of this study did not contradict the literature reviewed. Also, the model of healing is very general and further research is needed to make it more specific. When details of this model are defined, the possibility of contradictory evidence may be increased. As much of the literature does not specifically address healing, contradictions about the nature of healing are less likely.

With phenomenology as a guiding influence more explorations should be done on healing. Individuals in the process of healing would help illuminate more important aspects of healing and it is hoped that this information can be used to facilitate development of a body of knowledge on this important subject.

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APPENDIX

APPENDIX A

Consent to Act as Research Subject

Clayton College of Natural Health

THE EXPERIENCE OF HEALING

You are being asked to participate in a research study. Before you give your consent to participate, it is important that you read the following information and ask as many questions as necessary to be sure you understand what you will be asked to do.

I am Mrs. Katherine Agranovich, a researcher doing my master's thesis on experiences of healing. I am presently enrolled in the department of Natural Health Studies of Clayton College of Natural Health taking up a Doctoral program. My research advisor, Janice E. Martin, Ed.D., will monitor my study to insure that all the IRB policies are followed during the course of my study. The dissertation committee at my university and the International Review Board have both given approval to conduct this study, "The Experience of Healing."

The purpose of this study is to add valuable information about the growing phenomena of holistic health. It strives to explore the process of holistic healing. In the process of investigating the studies hypotheses, this study hopes to discover novel, unanticipated themes that help further our understanding of holistic healing.

In this study ten participants will be chosen. The participants are expected to demonstrate unique behaviours prior to surgery that appeared as if they might add important insight to the study. Further, in phenomenology it is important to choose participants who are able to speak with ease, express their feelings, and describe physical experiences (Van Kaam, 1966). All the participants are expected to be verbal and expressive and should have little trouble discussing their healing experiences. Participation to the study is voluntary. Potential participants will be the one responsible to contact the researcher and not vice versa. After the potential participants will call the researcher, a short interview will follow on the telephone to ascertain whether the participants met the requirements for the study.

This study will make use of the phenomenological research design hence selected participants will be asked to discuss their experience of holistic healing and the mechanism of their health creation process. Interviews is preferred to be done at the participants` or any mutually agreed place where they will feel comfortable and will be sufficiently relax to be able to talk about their experiences.

The purpose of the interview is to elicit information about the participants' experience in their own words, order of priority, and depth of emphasis. The interviews will usually lasts from 60 to 90 minutes or even longer. Then, it is expected that there will be two

interviews (first and a follow-up). Moreover, the interviews will be tape-recorded but pseudonyms will be substituted whenever the participant's name is used on the tape. The tapes, transcriptions of the tapes, information sheets, and any other materials written by or about the participants' actual names will not appear in any written reports, nor will they be used in any other way. None of the procedures (or questionnaires) to be used in this study are experimental in nature.

Risks are minimal in this study. It is anticipated that some of the questions may cause emotional trauma, thus the participants' emotional state will be assessed throughout the interview and time will be allotted to discuss if they will experience any difficulty during the interview. So, the participants are allowed not to answer any questions they do not want to answer. Also, participants are assured that they could withdraw from the study at any time, and that this would not affect their treatment in any way. Likewise, the investigators have the right to end participants' participation from this study for any of the following reasons: (i) it would be dangerous for the participant to continue, (ii) the participants are not following the study procedures as directed by the investigator, or (iii) the sponsor or the Clayton College IRB has decided to end the study. Further, the study will not entail any costs to the participants and that the participants will not be paid to participate in this study.

The study hopes to add valuable information about the growing phenomena of holistic health. It strives to explore the experience of holistic healing. In the process of investigating the study hypotheses, this study hopes to discover novel, unanticipated themes that help further our understanding of holistic healing. Moreover, with phenomenology as a guiding influence in this study, individuals in the process of healing would help illuminate more important aspects of healing and it is hoped that this information can be used to facilitate development of a body of knowledge on this important subject.

To protect participants' confidentiality, we will keep all facts about you private. However, persons other than those doing the study may look at study records. Those with the right to look at your study records include the Clayton College IRB. Records can also be opened by court order. We will keep your records private to the extent allowed by law. We will you're your initials rather than your name on study records where we can. Your name and other facts that might point to you will not appear when we present this study or publish its results.

If you have additional questions regarding the study, the rights of subjects, or potential problems, please call the investigator, Mrs. Katherine Agranovich (949-702-3228). If you have questions regarding your rights as a human subject and participant in this study, you may call the Clayton College IRB for information. The telephone number of the IRB is Toll free (877) 782-8236. You may also write to the IRB at:

Clayton College of Natural Health
IRB for the Protection of Human Subjects
Post Office Box 2488
Birmingham, Alabama 35201
Attn: Janice E. Martin, Ed.D.
Research Coordinator

Your signature below indicates that you have read the information in this document and have had a chance to ask any questions you have about this study. Your signature also indicates that you agree to be in this study and have been told that you can change your mind and withdraw your consent to participate at any time. You have been given a copy of this consent form. You have been told that by signing this consent form you are not giving up any of your legal rights.

_____
Name of Participants (please print)

_____ _____
Signature of participant **Date**

_____ _____
Signature of Principal Investigator **Date**

APPENDIX B

PRESUPPOSITIONS

1. Healing is more than a physical process.

2. A sense of personal wholeness and congruence with one's environment can enhance the healing process.

3. Psychological factors such as sustained anger, anxiety, depression or extreme dependence can interfere with healing.

4. Psychological factors such as happiness, a sense of purpose and hope can enhance healing.

5. Individuals can affect or have some control over their own healing.

6. There are things to be learned about the process of healing that will enhance the healer's ability to assist the process.

7. Healing occurs over time.

APPENDIX C

INFORMATION SHEET

Name (or pseudonym) _____ Date _____

Age _____ Sex _____

Occupation/Affiliation _____

Ethnicity: White _____; Black _____;
Hispanic _____; Asian _____; Other _____

General health: excellent _____; good _____;
fair _____ ; poor _____

With whom do you live, and what are their relationships to you?

_____

_____

Do you do anything specific to maintain your health? (i.e. medications, vitamins)

_____

_____

What illness or illnesses have you had?

_____

_____

_____

_____

What surgery or surgeries have you had? _____

reason _____

date of surgery _____

date of hospital discharge _____

Past surgery (ies) _____

date (s) _____

APPENDIX D

PILOT INFORMATION SHEET

I.D. # _____ Date _____

Age _____ Weight _____

Sex _____ Height _____

Do you live with : Mate (spouse or partner) _____
Roommate _____
Parent or other relative _____
Alone _____
Children _____

If you have children, what are their ages? _____

General health: excellent_____; good _____;
fair _____; poor _____

Do you smoke? Yes_____ No _____

Have you ever been told you were diabetic? Yes_____ No _____

Are you currently taking any medication, and if so, what? _____

_____

Do you take vitamins, and if so, what? _____

_____

Most recent surgery _____

reason _____

date of surgery _____

date of hospital discharge _____

Past surgery (ies) _____

_____

date (s) _____

APPENDIX E

INTERVIEW GUIDE

I am interested in what people experience when they heal.

> Since you are in the process of healing, I would like to know what you think happens while you are healing:

What do you think healing is?

Is there anything you experience in your body when you heal?

Is there anything you think happens in your mind when you heal?

Do you imagine anything (have images) when you heal?

Do things around you have an effect on your healing?

Is there any way that you can have an effect on your healing?

Did you have expectations about healing before your surgery?

Are there any spiritual issues related to your healing?

Do you believe that talking about the experience affects healing?

APPENDIX F

EXAMPLE MEMOS

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Beyond the Wound

Healing is so much more than a wound. At first this is the focus and individuals look with pride at how well they are doing because the body is healing this enormous gas. The vulnerable inside is covered and protected once again. It is almost miraculous how quickly this occurs. Because this is the most visible part of recovery it gives this illusion of rapid recovery. When all the other areas of healing unfold discouragement can be a result – perhaps related to getting the hopes up with rapid changes in tangible areas of recovery. Tiredness then becomes an elusive and frustrating problem. Emotional Ability and inability to handle things in accustomed manner are unexpected and difficult to deal with.

9/_ /2008

Healee's expect more from themselves when the visible exterior healing has been accomplished. People in the healee's life have this problem even more since they cannot feel the tiredness or read the more subtle clues that the healee experiences telling him that healing is not complete. Because they no longer look sick they are expected to resume normal functioning. Others often don't want to see the more subtle indications that the healee is not yet healed since they have been carrying an extra burden at work or home because of the illness. This lack of acknowledge of the continuing healing process adds another dimension to healing – frustration, pressure, guilt.

APPENDIX G

THEMES AND SUBTHEMES

Themes	Subthemes
Active Participation	The Goal is Control Healing is a Private Experience Emphasis on Uniqueness Attitude Heals Accurate Anticipation Intangible Tiredness Seeing is Believing Beliefs and Behaviors Regarding Physical Care Prior Surgical Influences
Achieving Balance	Mind-Body Incongruence Overdoing and Underdoing
Evolving Beyond	Life Review and Self-Examination Purpose Test of Expectations Spiritual Meaning
Healing Process	Beyond the Wound Toward Healing as Part of Life Privacy Progression Emotional Change Healing Milestones Temporarily

APPENDIX H

FOLLOW-UP QUESTIONAIRE

What parts of the description did you read?

Of the parts that you read, were there any that you identified with, i.e., any that related to your own healing experience?

Were there any that you could not relate to as being relevant to your healing experience?

Would you like to say anything more about these areas? If so, What?

Other comments?

Your level of functioning and health is:

better than it was before the surgery	the same as it was before the surgery	worse than it was before the surgery

APPENDIX I

PILOT STUDY

The Participants

The pilot study was done with two participants, Feona and Catrine. Feona is a 56-year-old woman who had a benign tumor removed together with the uterus after severe abdominal pain and bleeding. She has had two prior operations: A malignant tumor in a thigh fifteen years ago and mastectomy due to malignancy four years ago. She considered her health good prior to this surgery. She is a non-smoker and ten pounds underweight. Feona works part time as a clerk in a clothing store. She is married to a school teacher and has two sons. She was been paying for college for her sons, one having already finished and the other having one year left to complete.

Catrine is a 34-year-old woman who had a partial oophorectomy for endometriosis. It was expected that she would have a hysterectomy and because she and her husband have no children and they would like to have them, the outcome of the surgery was a happy surprise. Her husband has an eight-year-old daughter from a prior marriage. Catrine considers her general health to be excellent. She does not smoke and is of normal weight. She is a marketing manager assistant for architectural firm and enjoys working.

Both Feona and Catrine were interviewed twice; once about a week after surgery and again approximately three weeks after the first interview. Both were willing to talk about their experience in the context of healing and had no trouble with the questions.

Uncertainty and Control

Neither Feona nor Catrine described healing as a totally passive process. They both perceived themselves as having some control. Feona placed a strong emphasis on the need for positive thinking and for avoiding negative thinking. She actively pursued this positive thinking goal to the point of trying to say nothing negative about this very difficult experience. When she was unsuccessful, any negative statements were usually followed quickly with positive statements. For example, in discussing her persistent gas pains she commented that her doctors “don’t know the answers to that at all.” This was quickly followed by a statement, “I love the surgeon. He is a very intelligent man.” She has studied Norman Vincent Peal and believes that his style of thinking has helped her through many tough situations in the past. Unfortunately she does not feel as much control this time. She has a much harder time healing than she expected and attributes this to the stress due to uncertainty of the tumor, before the pathology report revealed that the tumor was a benign fibroid.

Catrine does not use positive thinking in the same way, but hates to be sick. She actively tries to reduce the importance of the illness and spends as little time acting as if she were ill as possible. She planned this surgery (though it was not elective) around her and her husband’s birthdays with three weeks in between for surgery and recovery. She

played a very positive character in a role just prior to surgery, and she believed this helped to create a feeling conducive to healing.

The Need to Talk

Feona found it very puzzling that she has a strong urge to talk about her surgical experience. She saw this as a need and was surprised to find herself relating her experience to people she was barely acquainted with. Each telling seemed to aid the healing and the need to tell gradually diminished. Part of the healing occurred when people let her know she was not the only person who had such a massive growth. She was happy to hear others had survived and did not have reoccurrence anywhere else.

Catrine avoided talking to people prior to surgery since she believed they might tell her "horror stories" and therefore add to her worries, which might in turn slow her healing. After surgery however she called "everyone she knew," ostensibly to pass the time, but perhaps she also had the need to tell.

Emotions

Both Feona and Catrine believed worry would interfere with healing. Catrine was able to avoid it for the most part and she healed rapidly. Feona, who healed more slowly than she thought was normal, worried more than she would have liked, about: dying; contracting AIDS from the transfusion; future tumor growth; and whether this tumor was really benign. Catrine believed she could "freak herself out." She strongly believed worry should be avoided and was angry at a friend who insisted that she could not possibly heal enough to have her and her husband's birthday party in three weeks after surgery as she had planned.

The strongest emotion Catrine attributed to successful healing was that of relief and happiness that she could still have children. "I felt like I got a reprieve from the governor . . . . as a result I really healed much faster than I think is normal."

Purpose versus Boredom

There seems to be a decline balance between purpose and boredom. Boredom was a problem with both Feona and Catrine. Lack of energy and ability to focus made activities to alleviate boredom difficult to find. Long visits were tiring, books difficult to read, and television not stimulating enough. Both felt boredom was not conducive to healing and actively pursued ways to alleviate it.

Feona's best friend's husband died while Feona was sick. The friend expresses a desire for Feona to get well quickly so she could be supportive of her. Feona believed this sense of purpose, to be strong for her friend, was a very powerful motivator to heal. She saw her husband and sons as helpless to take care of themselves and therefore needing her, thus adding a sense of purpose to get well. Her physician/boss also expressed a desire for her to get well since he "can't run the office without her." She resented this and did not look at it as constructive in her healing process. What was healing about going back to work was a reconnection with the outside world.

As a marketing manager assistant, Catrine sees herself at a vulnerable stage for her career. Busy with arranging public relation meetings and marketing campaigns, she did not want to take more than three weeks away from work. Besides, she was excited to plan her and her husband's birthday party. She believes her healing was enhanced by this sense of purpose.

Memories and Expectations

Memories and expectations were perceived to play a part in both Feona and Catrine's healing. Feona had had prior surgery and believed that helped her to know that the first day would be bad but things would get better. Also memories of her husband's recovery from severe depression and both her sons surviving potentially fatal illness increased her optimism which in turn, she believes helped her to heal. Unfortunately, other memories, such as family members dying of cancer and her own two cancerous tumors that she had had removed in the past, made her struggle with positive expectations. She found herself constantly battling between painful memories of the past and positive thoughts of the future. Her most powerful experiences that she believed helped healing were: a friend whose husband died asked her to get well quickly so she could help her cope; one son expressed unexpected emotion and support; and another friend sent her a different card every day for two weeks. She had a lot of other support from family and friends but these incidences were the most remarkable because they were all unexpected. Social experiences that she viewed as hindering healing related to nurses being too busy to give her pain medication, lecturing her about the danger of addiction, and not having time to get her up to walk. Feona also would have liked a better bedside manner, more support and more information from her physicians. Three interns were particularly troublesome to her.

Catrine did not make as clear a connection between social support and healing. She had many supportive people around. Her husband sounded particularly thoughtful. She wanted to de-emphasize her illness to her step daughter and was frustrated at her mother-in-law not being more thoughtful. She resented people who told her how she would react to surgery. She viewed surgery as a personal experience. "This is my body and I will have my experience." Catrine respected her doctor's knowledge but thinks a kinder bedside manner would have been beneficial.

Environment

Both Feona and Catrine thought the hospital was not a good place to heal. Feona was appalled with the noise, light and activity of the intensive care. She found the food terrible. However she did not feel ready to return home when she did. When she got home she did find it a more healing place.

Catrine's reaction to the hospital was also negative with a repeated thought of "let me out of here." An understanding was gained of her mother's conversion to the Christian Science religion after a similar surgery to Catrine's, at a similar age. "Come to think of it, I can see why someone might leave the hospital environment thinking there must be a better way to heal.

Both Feona and Catrine found the challenge of work useful in the healing process. Feona, however, believed she was returning seemed to be as more important issue than the actual return.

Because Feona's insurance ran out she had to leave the hospital before she was ready. This provoked a comment "these people who don't have insurance have more trouble healing."

Physical Issues

Pain was perceived very differently by each participant. Feona felt more pain than in past surgeries and she has trouble getting relief from pain. Catrine felt pain during intravenous antibiotic administration before surgery but did not perceive the incision as painful, only numb and uncomfortable. Could these perceptions of pain relate to different mental states? Feona was tense, frightened, and uncertain after her surgery and found that time very painful. Catrine had pain before her surgery when she too was tense and uncertain but not after surgery when her problem was more clearly defined.

Feona described her hobby-singing as an ideal exercise to return one's abdomen to normal since it is gentle yet frequent. Catrine started a program of exercise to retain a tight abdomen. Both described incidents related to walking that were perceived as markers of successful healing.

Catrine advocated not draining your energy since "energy level has lot to do with how to heal." Energy can be drained in both physical and emotional ways. Feona has a much more passive relationship with her energy. If she regained energy, she was healing.

Faith

Faith was discussed by both Catrine and Feona. Feona has a very active faith which she describes as relating strongly to healing. However several attempts were made to discuss the importance of her faith in healing but it did not become clear to me how it differed from her positive thinking; she though that she could get well if she believed she would.

Catrine described, not her own faith now, but the influence of her Christian Science up bringing. Catrine is not a practicing Christina Scientist religion. However, being sick provoked thoughts about her method of coping and its relationship to her training. She learned to de-emphasize illness and to accept it yet get on with her life as quickly as possible if she did become sick.

Time to Heal

Feona felt that having enough time to heal was important. She had to leave the hospital early because of her insurance. Upon returning home she had to resume cooking immediately and she felt her boss pressured her to return to work before she was ready. She believed all these circumstances made it harder to heal.

Catrine had her own time schedule and she resented any case one trying to impose their timing on her.

Definition

Both participants discussed energy level as one yardstick of healing. If energy is returning, they are healing.

Both talked of healing as not just physical. Feona was the most verbal about how to define healing. Healing to her id "kind of getting things into perspective – in the background of where things should be, I guess. Getting on with life . . . and returning to some kind of normalcy." She talks about physical yardstick of healing such as how far she can walk. Another important yardstick was the fact that she had resumed planning for the future.

APPENDIX J

DATA RECORDS

Raw Data

audio recordings-entire interview was recorded

transcriptions –verbatim encoded form of the recordings, with wide margins for coding

information sheet – filled out by each participant

filed notes – comments and descriptions by the researcher related to each interview

participant journals – written thoughts about healing

follow-up questionnaire – comments by participants about the themes

Data reduction products

code file – evolving codes used to analyze the data

coded transcriptions – key phrases underlined codes and comments in the margins

consolidation of codes – quotes under each code grouped together

Data reconstruction and synthesis products

analytic memo- thoughts about relationships in the data

analytic log – synthesis of memos and hunches about emerging frameworks

descriptions – themes described taking the data into account

final reports – synthesis of the findings
- Dissertation
- any other reports on the findings

Process notes

proposal – submitted prior to data collection

methodological log- comments and changes in method, schedules, and logistics of the study

process diary – date, procedure, and comments to coordinate the data sources

time line – interview schedule

Personal notes

Personal log – personal reflections and documentation of advisor and critique

APPENDIX K

CODES

Process- Pro	Healing – Hlg	Balance – Blc
	Interrelationships – Irl	Mind-Body Connection - MBC
	Description of surgery – S.D.	
	Comparison of past & present surgery – PS-PS	
	Question further - Q	

Physical-Ph	Age-Ag	Medication-Mc
	Care-Cr	Nutrition-Nu
	Comfort-Co	Overdo-Od
	Complication-Op	Pain-Pa
	Energy-Eg	Protection-Pc
	Exercise-Ex	Rest-Rs
	Feedback-Fb	Sleep-Sl
	Function-Fu	Symptom-Sy
	Health-He	Tone-To
	Incision-In	Tired-Tr
	Loss-Lo	Visible-Vi
Personal-Ps	Assumption-As	Images-Im
	Attitude-At	Insights-Is
	Belief-Bl	Knowledge-Kn
	Career-Ca	Life Style-Ls
	Confidence-Cd	Memories-Mm
	Control-Ct	Put-down-Pd
	Change-Cg	Plan-Pe
	Choice-Ch	Purpose-Pp
	Denial-Dn	Self-Esteem-Se
	Dependent-Dp	Spiritual-Sp
	Discipline-Ds	Trust-Ts
	Empathy-Ey	Thoughts-Tt
	Escape-Es	Temporality-Tp
	Expectation-Ep	Uncertainty-Uc
	Experience-Ec	Uniqueness-Un
	Goals-Gl	Values-Va
Emotional-Em	Anxiety-Ax	Guilt-Gt

	Anger-An	Happy-Ha
	Blame-Bl	Hate-Ht
	Bored-Bo	Hope-Hp
	Calm-Cm	Sad-Sd
	Depressed-De	Upset-Us
	Embarrassed-Eb	Worry-Wo
	Fear-Fe	Humilated-Hm
	Frustration-Fr	
Environment-Em	Comfort-Cf	Quiet-Qt
	Food-Fo	Stress-St
	Home-Ho	Time-Ti
	Hospital-Hl	Timing-Tg
	Housework-Hw	Work-Wk
	Noise-Ns	
Social-Ss	Family-Fm	Nurse-Nr
	Friends-Fd	Other-Ot
	Mate-Mt	Physician-Md

The Ps, Ph, Em, En, Ss and Pro define the general categories but at time a qualifying code will be taken from another category and used after a general code that is not the usual general code for that particular qualifying code.

APPENDIX L

CODED CATEGORIES

Age
Attitude
Balance
Change
Choice
Complications
Confidence
Control
Death
Depend
Emotions
Energy
Environment
Exercise
Expectations
Feedback
Functioning
Goals
Healing
Health
Incision
Isolation
Life Review
Medication
Memories
Mind-Body
Nutrition
Overdo
Pain
Past
Purpose
Self-Esteem
Social
Spirituality
Stress
Surprise
Survivor
Talk
Temporality
Tiredness
Uncertainty
Uniqueness
Values

APPENDIX M

PARTICIPANT JOURNAL

ID#_____

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APPENDIX N

PROCESS DIARY

Date	Procedure	Comment