Psychiatric mental health nursing and holistic nursing could be thought of as fraternal twins. They come from the same stock – valuing a person's unitary wholeness.

Hildegard Peplau, one of nursing's major theorists and the grandmother of psychiatric mental health nursing, developed the theory of interpersonal relationships for all of nursing. In the editorial introduction of Peplau's 1952 book, _Interpersonal Relationships in Nursing_, Genevieve Knight Bixler explains that Peplau's psychodynamic theory is “... essentially organic, nursing being presented in its wholeness, rather than being compartmentalized...” (xvii). She explains that a guiding assumption for Peplau's theory is that “the kind of person each nurse becomes makes a substantial difference in what each person will learn as he is nursed throughout his experience” (Bixler, 1952, p. vii). In more contemporary words, how a nurse “matures” and is self-aware and self-assured affects the patient's experience. Peplau's wholistic theory “provides an enlightened design for living as well as a modern design for nursing” (McManus, 1952).

Two aspects are important in considering the fraternal twin metaphor for psychiatric mental health and holistic nursing: (1) the conceptual basis for practice and (2) integrating holistic approaches and complementary modalities.

**Conceptual Basis**

The first aspect in the fraternal twin relationship is the overall approach and conceptual base underlying practice. Both holistic nursing (HN) and psychiatric mental health nursing (PMHN) share similar foundational principles and seek to answer common questions (see sidebar at right). Here we see concepts and concerns valued by both specialties. While some concerns receive greater emphasis in one specialty or the other (i.e., relationship in PMHN and spirituality in HN), both value the role of self, intention, and intentionality, and the therapeutic relationship in the context of a whole.

Each person's inherited gifts, liabilities, and characteristics are continually interacting with their evolving psyche, spiritual life, relationship to community, and culture. All of these aspects manifest as a unique pattern of a person's unitary wholeness. Appreciating one aspect without the others leaves a fragmented puzzle and an incomplete picture. This whole person is in constant relationship with others and the environment; these relationships also create patterns. Pattern reflects the nature of the individual and is usually perceived energetically – the person's “vibe.” Similarly, relationships exude a vibrational pattern such as observing a loving parent with a child.

I am using the terms unitary and wholeness (holistic) in the same sentence recognizing that they represent two different world views. According to the American Holistic Nurses Association (AHNA), “Holistic nursing recognizes that there are two views regarding holism...Holistic nursing responds to both views, believing that the goals of nursing can be achieved within either framework” (AHNA & ANA, 2013, p. 1). Holistic implies that separate parts are interacting to create a whole. Unitary is more abstract and focuses on the pattern of the whole rather than the interaction of parts. We embrace both definitions in holistic nursing, recognizing that the goal is to value one's self and persons, families, cultures, and systems as unique wholes whether looking at the interactions of individual parts or observing an energetic pattern to understand the whole.
Much of medicine, and nursing as well, adopts the particulate approach by focusing on a single part or the interaction of multiple parts to understand illness and devise interventions. In contrast, both holistic and psych-mental health nurses value the wholeness of individuals within relationships, families, and communities. Both view health and well-being ultimately as an expression or manifestation of wholeness. Our goal as holistic psych-mental health nurses is to help restore wholeness by promoting the transition from illness into health and maintaining health while preventing further dis-ease. This encompasses recognizing people’s innate health, strengths, and gifts, and helping them do that as well. Both groups of nurses embrace a health appreciation and a growth model.

Modalities
The second aspect in the fraternal twins relationship of holistic and psychiatric-mental health nursing is integrating holistic modalities into practice. For example, establishing a therapeutic community within an inpatient or partial treatment program is a holistic modality. Within a therapeutic community, all of the staff, including those responsible for cleaning and dietary services, meet with all the patients and work together as a unit to ensure all needs are met. Recognizing that the patient is part of a bigger whole, families are essential in therapeutic community.

In my psychotherapy practice, I integrated imagery, relaxation, and hypnosis as well as the Emotional Freedom Technique (EFT) and occasionally Therapeutic Touch. I also taught these modalities to nurses in all practice specialties.

In 2000 and 2008, I published articles on holistic, alternative, complementary approaches for psychiatric nursing. I discussed modalities such as light therapy, dietary supplements, lifestyle and exercise integration, herbs, massage, acupuncture, electromagnets, and homeopathy for depression (Zahourek, 2000). A theoretical base and intentions formed in holism, as opposed to allopathic medicine, was emphasized for interventions to be considered truly holistic (Zahourek, 2008). Many of these interventions have been extensively researched and can now be considered or avoided based on data published on the National Center for Complementary and Integrative Health website (https://nccih.nih.gov). Meditation, massage, movement therapies, and some energy interventions such as EFT or Thought Field Therapy (TFT) are now practiced and supported by research for treatment of depression, anxiety disorders, and post-traumatic stress disorder. Other complementary and alternative interventions (e.g. supplements, Yoga, acupuncture, etc.) are being studied for other illnesses including eating disorders, ADHD, sleep disorders, and dementia.

My Path
I was surprised to find my psychiatric nursing niche in my BSN program. I was always oriented toward science and biology. Psychology and sociology – the ‘soft sciences’ – baffled me and gave me a headache. Hand me a petri dish and a microscope, and I was happy. What turned me around? I had an inspiring PMHN instructor who was supportive of her students after other instructors had seemed demanding and difficult to please. During my clinical experience, I was assigned to a young schizophrenic man at the Veterans Administration Hospital in New York City. He was obsessed with spoons, collecting, drawing, and storing them in his drawer. He was nearly mute and fearful of extended contact with others. It was a challenge to form a relationship with him. How could I best understand him if he didn’t communicate verbally? I learned to sit quietly with him, telling him I would be there for 5 or 10 minutes; if he wanted me to leave, he could just wave his hand. I learned to pick up on non-verbal cues and assess his physical well-being from subtle signs (a dry mouth and offering him water). I persevered. I drew and traced spoons with him until there was a semblance of communication and trust. He allowed me to spend more time with him, and we formed a basic relationship. I was fascinated and gratified. I had always been interested in how relationships developed; I wanted to learn more. What created helpful or harmful systems? How do relationships create physical and mental challenges or health for people?

I completed my bachelor’s program in the mid-1960s. The program was unique in being what I would consider “holistic” for the time. While the language was not contemporary, we learned that people are complex systems that include mind and body as well as families and community. All these components interact together to create a person’s coping capacity and determine where they might be on the health-illness spectrum.

After staff nursing on a psychiatric medical center unit, I was encouraged to go to graduate school and enroll in the psychiatric mental health clinical specialist program at the University of Colorado. The new program director and my supervisor was Madeleine Leininger, PhD, founder of the Transcultural Nursing movement. My minor was anthropology (her specialty) which added the role of culture in mental health and illness to my holistic understanding.

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My first post graduate job was as a research assistant and mental health consultant to the general hospital nurses and staff at Denver General Comprehensive Community Mental Health Center. Here I saw first-hand the whole relationship of mind, body, and spirit in the social-cultural context of the general hospital. This holistic awareness included both patients and staff in the highly charged hospital environment. Each whole person interacted with other whole persons. Injury, death, birth, chronic illness, crises, joys, sorrows, and healing all created a unique high-intensity pattern in which dependent individuals (patients) and their unique social systems interacted with the equally unique staff's social system and their attempts at management and control. Patients were strangers in the environment while the staff was accustomed to hospital demands and stressors. Frequently situations arose in which problem patients (often given a psychiatric label like dependent, hysterical and malingering, etc.) had conflicts with the staff. Usually by the time I was called, there was a crisis brewing. It was important for me, as a consultant, to have empathy, provide support, and be present while working with patients, families, and staff, particularly in situations where there was no clear solution to a problem. I had to see the whole picture – the pattern – in order to be effective.

I had a small caseload of therapy patients. One patient, Diane, particularly impacted the rest of my career as a holistic psychiatric mental health nurse (see Diane's story below).

Diane was a single mother of two young daughters. She had become a chronic pest to the entire hospital system. She was very needy and often in the emergency room with various complaints – atomic bladder, intense abdominal pain, headaches, sprains, and minor injuries. The staff called her a “crock,” “histrionic,” a “malingering,” and “non-compliant.” Some of her complaints resulted in medical surgical admissions while others in psychiatric admissions. I had been working with her individually and in a group for more than a year, and gradually she was improving. We suggested she work in a sheltered workshop for the severely mentally ill (while she had none of the outward signs of severe mental illness, she was functioning at a marginal level for her level of intelligence and mental status). She blossomed there, gaining much self-confidence. The constant trips to the emergency room stopped. She was more involved with her children, even though by then they were in the full-time care of her mother.

One day, I received a call from the intensive care unit nurse. “Your patient Diane is here, and she is in terrible shape. She is badly burned and screaming non-stop. Nothing we give her helps, and we’re going crazy with her; please, you have to do something!” When I saw Diane, I was shocked. Her nightgown had caught fire while she was cooking, and her upper torso was covered in second and third degree burns. Her head was swollen to what looked like twice its size. Her arms were swollen and oozing to the extent they had to be lanced. Red weeping charred areas made my stomach turn. I felt at a loss. For the next two days, she didn’t sleep and didn’t eat. She was in constant pain, crying, screaming, and demanding excessive pain medication. The staff was exhausted.

When I was a student during my obstetric experience, I had a patient who lived on a commune and was using a “natural child birth” method to deliver. She practiced breathing and focused attention to relax when she had contractions. Later I took a behavioral therapy workshop in which imagery techniques were taught. I thought maybe these two techniques might help Diane if I could get her attention. I told her I had an approach that helped others with pain and that all she had to do was listen to my voice and do what I suggested as best she could. She was willing to try. I asked her to close her eyes when she felt comfortable and take a nice relaxing breath. I suggested that she would have a pleasant, relaxing trip that would allow her pain medication to work faster and more effectively. She would be more comfortable and able to rest and heal. She closed her eyes, her breathing slowed, and she began to relax. The following imagery popped into my mind, and I decided to trust my intuition. “Visualize a meadow – green, lush, and comfortable. The air is warm and light. Take in all the sights, sounds, and smells – the freshly cut grass. The grass is a very, very intense green. Can you see it?” She nodded her breathing had slowed; her eyes closed. “The grass is soft like velvet. You can lie down and rest; it’s like resting on a green velvet cloud. And you are warm and comfortable.” Like many burn patients, she was always cold. She fell asleep! Everyone was shocked and relieved that she slept.¹

I continued to do these relaxation-imagery exercises with her daily. Several staff became interested and noticed that she was calmer and easier to manage. As they watched me work, they also became more relaxed. I continued working with her during painful dressing changes and taught the staff how to reinforce the techniques when I was not present. She required pain medication less often, and her sleeping and eating improved. The staff began to find her more interesting and easier to work with. Both the staff and Diane felt more in control – a unitary whole pattern change had emerged. While Diane died of unexpected complications three months later, my experience with her inspired me to continue integrating relaxation, imagery, therapeutic suggestion, and hypnosis into my practice.

A social worker and I devised a program using these techniques with burn patients and later with difficult patients on the surgical unit. We helped ease the burden on staff by working with their least favorite and most demanding patients. We also helped a burned patient, who was allergic to general anesthesia, using hypnosis for two skin grafts. The staff were interested in these approaches and, when possible, participated in reinforcing them. The system was a unitary whole. As patients were supported and became less anxious and demanding, the staff became more relaxed, less frustrated, and more engaged with the patients.

I learned Ericksonian hypnosis, which incorporates indirect suggestions and utilizes metaphor and stories as a means of subtle but powerful communication and relationship building. Interventions are crafted and executed with the unique characteristics of the person being treated always in mind. I continued to incorporate relaxation, imagery, and hypnotic techniques throughout the life of my psychotherapy practice. I integrated drawings, mandalas, collage, and later EFT into my basic psychotherapy approach, which was based originally in Peplau’s interpersonal relations and psychodynamic theories. I believe these augmented and created a holistic-unitary form of psychotherapy approaches for patients who had phobias, chronic anxiety, depression, substance abuse, obesity, and chronic pain. I taught the techniques and wrote articles and books for caregivers about these interventions.

My orientation in all of my practice – psychotherapy, consulting, educating, and even when prescribing – was always that I was dealing with a whole person and that I was a whole person involved in their energetic and patterned space at a certain point in time. Helping people relax and use their imaginative skills expanded their coping mechanisms, gave them access to other areas of their consciousness, and enabled my interactions with them to be on a highly personal and energetic level. When I used these techniques, I also relaxed and focused on the experience as an expansion of my understanding of the person and the process in which we were engaged.

The Evolving Field of Psychiatric Mental Health Nursing
The field of psychiatric nursing has expanded greatly in the last 80 years. With advanced degrees, psychiatric mental health nurses are now functioning independently in various settings and, in most states, have prescriptive authority. In many settings, psychiatric nurse practitioners are largely prescribing psychotropic medications and doing less psychotherapy. While there is an alarming risk of losing a nursing therapeutic and holistic approach, there are many nurses who function holistically in a prescribing practice. Although challenging, a therapeutic healing relationship and process can still be established and developed in a 20-30 minute medication management encounter. The nurse, however, must have that intention and develop the skills necessary to maintain a holistic-unitary approach as well as integrate complementary modalities.

In summary, many holistic nurses are also psychiatric mental health nurses and vice versa. I recently saw an ad written by a “Wholistic Psychiatric Nurse Practitioner Practice Group” seeking a holistic psychiatric nurse practitioner to “provide medication management and therapy visits focused on treating the whole person.” I noticed that the next American Psychiatric Nurses Association conference will be offering workshops on self-reflective practice, promoting wellness and recovery, the effectiveness of HeartMath, and a mindfulness track. We’ve certainly come a long way! The fraternal twin relationship is becoming increasingly apparent as both specialties evolve in theory base, research, and practice.

REFERENCES