I have to admit in my role as your E-news editor I might be labeled as somewhat of an information junkie. I spend a lot of time looking at information to decide what is important to bring to our membership. One concept that has repeatedly arisen over the last year is the concept of mindfulness. It is not a new concept at all, as it is grounded in the Eastern Buddhist philosophy of suffering (White, 2013). However, when concepts become more mainstream, I have found that their true meaning and implications for our professional practice become unclear. The word mindfulness used in various contexts leaves me, the healthcare professional, uncertain about its implications for practice. As a result, I went to the literature to discover what mindfulness is really about.

When doing research, I find it makes more sense to me to complete it sequentially. If I want to find out about the meaning of a concept, I look to see if a concept analysis has been completed. Through a systematic method, the researcher evaluates the key components of a concept to look at its true meaning. Not only does this enhance our knowledge about the concept but it also provides an opportunity to look at its meaning relative to other related concepts to identify the defining characteristics. Regardless of the methodology used to complete the concept analysis, the researcher typically concludes with the implications for nursing practice and research. I find that when I read a comprehensive analysis I can then use the evidence in my practice.

White (2013) completed a concept analysis of mindfulness in nursing using an evolutionary approach. In her research, she identified the attributes of mindfulness as a "transformative process where one develops an increasing ability to 'experience being present,' with 'acceptance', 'attention' and 'awareness' (pg. 282)." The antecedents of a concept are those things that must come prior to the concept. This
was identified as formal or informal practices that support the attributes of mindfulness based on the individuals' preferences (White, 2013). They include practices that focus on breathing and being present in the moment. White (2013) states that because mindfulness is a process, there is the opportunity for overlap between the antecedents and the attributes of the concept. The consequences of mindfulness are an "improvement in physical and mental health as well as changes in personal behavior" (White, 2013, p. 288). This can be demonstrated in decreased anxiety, depression, increased levels of empathy, more control over our internal and external reactions and new or improved spirituality.

What does this mean for our practice? I think the implications are limitless. First in a profession that gives so much with very little formal education on the practice of self-care, mindfulness is an intervention that can promote self-care activities. Through improved self-care and an ability to enhance our empathy, there is the opportunity to prevent such consequences as burnout and compassion fatigue. Mindfulness has the potential of being a significant health promotion intervention. Additional research is needed, both qualitative and quantitative, to evaluate the implications of this intervention for our nursing practice and the relationship it might hold to nursing theories such as Jean Watson's Theory of Caring. Being a Philomath, reading research gives me the impetus to get out there to see if we can close these knowledge gaps in our practice. Happy researching! Bonnie


Clinical Research is my focus and passion, particularly exploring nursing interventions that can help our clients achieve their optimum levels of wellness, even in the face of chronic diseases, the normal changes of ageing, and/or other situational stressors in our environment. But I include nurses in the term 'clients' because we too need to learn how to take care of ourselves and take care of each other, as well as providing excellent clinical care for our clients.

Could you tell us how you got started in research and how it evolved over the years?
My first experience in research was in 1990, doing data collection as a research assistant for someone else's doctoral dissertation. She was very passionate and switched on, with a love for research in general, not just for her own project. Being part of something exciting that reached a successful conclusion was a lovely first experience in research, and helped cement my desire to further my own education.

I then went on to do my own research for my Masters at SDSU, which I completed in 1998. I did a quantitative correlational study about the emerging specialty of telephone triage nurses, looking at their levels of job satisfaction, organizational commitment and organizational instability. Telephone triage RNs had reasonably high levels of job satisfaction and organizational commitment as compared to other RN specialties, but both traits were negatively correlated to organizational instability. It was a timely topic, since an organizational restructure deleted our whole telephone triage department the following year! But that event was the catalyst that spurred me in to an academic career, as I then began to do clinical facilitation and found that I loved teaching.

In 2001 we moved to Australia, and I continued my new found teaching passion at the local James Cook University, where I still work today. While working full time, I did my part time PhD, from 2007 to 2013. I conducted an RCT that compared Healing Touch to a placebo (mimic or simulated Healing Touch). We found that the older women who received Healing Touch improved their functional ability to perform Basic Activities of Daily Living (ADL), when we tested them 6 months after completion of their series of 7 weekly Healing Touch sessions; while the placebo group demonstrated a decline in their ability to do ADLs at that same time point. The differences between the two groups reached statistical significance, the 'holy grail' in quantitative research.

With the ink finally dry on my PhD, I'm now in the 'post doc' phase, where I take what I've learned about the process of doing research, and use it to initiate other research projects, either on my own, with clinical collaborators, and/or by mentoring research students as they conduct their own research. Currently I'm involved in 4 clinical collaborations and also on the supervisory teams for projects by 1 PhD student, 2 Masters' students, and 2 Honours students. (Here in Australia, an Honours degree is a one year, full time research project that students undertake either immediately after completion of a Bachelor's degree, or within five years of graduating. It is an entry level research qualification, after which students can direct their career trajectory towards a research specialty.)

What were some of your biggest challenges, surprises and joys in doing holistic nursing research?
The joy always seems to be the people doesn't it? The older women in my PhD research were such a treasure, and it was a privilege to meet and spend time with them giving them their
Healing Touch treatments in their own homes. And watching my research students have those 'aha' moments when they 'catch the bug' for all the exciting discoveries that research can unveil for us is also a joy. In this phase of my career, as I'm meeting and creating linkages with clinicians to help them enact clinically relevant research in their own contexts, I am always struck by how committed they are to the profession of nursing, to growing the body of knowledge, and mostly to providing an excellent clinical nursing service to the clients in their care.

The challenges are always about time for me, because doing it right does require the expenditure of time.....and yet I'm rather fond of my sleep! But the more research projects I am involved in, the more I realize we don't always have to do it the hard way. There are some key design decisions that we make at the beginning of a research project that can make it all much more manageable, while still ensuring we do robust, high quality research that we can be proud of, and that also makes a substantial contribution to the profession and to client care. For many of the complementary therapies that holistic nurses embrace, the body of evidence from research is still minimal, with under-funded and under-powered studies. Yet it is the research evidence that is needed to persuade policy makers and insurance providers to reimburse practitioners to provide these therapies to our clients.

What advice would you like to share with holistic nurses just getting started in research?
There is a 'speed dating' element to research collaborations! Choose wisely who you work with, but do work with someone---get yourself on research teams where you can contribute by doing a small, manageable portion of the project, and learn as you go. Clinical research lives or dies based on how well the nurses in the unit support the data collection efforts, so there is always a role to play. Be brave, put your hand up, and get in to it! Your current and future patients will benefit from the research projects that your contribution helps to make successful.
And don't be afraid of research, it doesn't bite. Nurses are clearly more than smart enough to do research, it is not beyond us, and don't let yourself believe that research is only for someone else. What a successful research project needs the most is actually an awful lot of 'horse sense' or common sense, and we know that nurses excel at that skill. Use the 'research consultation' service from AHNA to get some advice on the nuts and bolts, and then get moving.

What excites you about the future of holistic nursing research?
I see a lot of 'demystification' of the research process going on, and that excites me. Research is our birthright as nurses: Florence Nightingale was a keen researcher and we can all follow in her footsteps. Research does not belong to the elite, it belongs to the entire profession, and we all have a role we can and should play to build the body of nursing knowledge. There is a vocabulary to research, but it is easily translated and once you know the language, you can widely travel the exciting territory of research and see all that it has to offer for you as an individual nurse, and more importantly, for all the clients you will care for in the future....and even beyond the duration of your own career. Research is the legacy we leave for the next generation of nurses.

Please add any additional comments you may have about holistic nursing and/or holistic nursing research.
The holistic philosophy holds the answers to our current health care crises. We need to design and do the robust research on what we have to offer, so that we can provide compelling evidence to insist on integrating holistic care into the health care systems in our countries. Only then will our future clients get the full spectrum of care that they need and deserve to achieve optimum wellness, at any age and while managing any health condition.

AHNA 2015 Conference - Research Posters/Papers List

Here are some of the research highlights from the upcoming AHNA 35th Annual Conference. Learn more about conference at www.ahna.org/conference

Research Posters

**Development and Testing of an Instrument to Measure Holistic Attributes of Nurse Practitioner Care** - Elizabeth Kinchen, RN, MS, AHN-BC

**Assessing Risk for Strain in Caregivers of Persons with Parkinson’s Disease: A Holistic Approach** - Maryann Abendroth, PhD, RN

**Empowered Holistic Nursing Education: Achieving Interconnectedness in the Online Class** - Katie Love, PhD, RN, PHCNS, BC, AHN-C

**A Randomized Control Trial of the Effects of Healing Touch for Newborn Male Infant Circumcision Inpatients** - Laurie Bourn, BS, RNC-NIC, ASPMN-BC and Marty Downey, RN, MSN, PhD, AHN-BC, CHTP, CNE

**The Effectiveness of Two Holistic Therapies in Reducing Test Anxiety Among Nursing Students** - Marty Downey, RN, MSN, PhD, AHN-BC, CHTP, CNE, Janet Willhaus, PhD, RN, CHSE and Alia Crandall
Grounded in Mindfulness: Fostering Self-Care and Presence in the Classroom - Debra Van Kuiken, PhD, RN, Jennifer Bradley, PhD, RN, GPCC, Barbara Harland, MSN, MED, CNL and Margaret King, PhD, RN-BC, AHN-BC, CNL

Comparison of America’s South Central States Position on Complementary and Alternative Medicine - Tamisha Gatewood-Henderson, MSN, RN, CCM, MHA

Teaching Nurses Reiki Energy Therapy for Self-Care - Angela Brathovde, MSN, RN, BC, HNB-BC

Research Papers

Caring Outcomes from a Holistic-Integral Curriculum - Carey Clark, RN, PhD

Development and Testing of an Instrument to Measure Holistic Attributes of Nurse Practitioner Care - Elizabeth Kinchen, RN, MSN

Nursing Perspectives on the Usefulness of Integral Theory in Nursing Practice and Education - Linda Shea, PhD(c), RN

The Use of Simulation to Instruct Nursing Students in Stress Management: Pilot Testing of the NURSE Intervention - Colleen Delaney, PhD, RN, AHN-BC, Cynthia Barrere, PhD, RN, CNS, AHN-BC, FAAN, Sue Robertson, RN, PhD and Rorry Zahourek, PhD, PMHCNS, AHN-BC

Acknowledging Praxis: Recognizing Caring in Reflective Narratives of Pediatric Nurses - Mary Enzman Hines RN, PhD, CNS, CPNP, APHN-BC

The Ethical Caring Theory of Existential Authenticity: The Lived Experience of the Art of Caring and Healing in Nursing Administration: A Holistic Approach - Marilyn Ray, RN, PhD, CTN-A, FAAN

Faith Based Caring: Research Supports a Historical Front-Runner in Holistic Nursing and 21st Century Opportunities - Susan Dyess, PhD, RN

Men in Holistic Nursing: Caring, Healing and Intentionality - Rorry Zahourek, PhD, RN, PMHCNS-BC, AHN-BC

Creative Expression with Women Who Have Experienced Emotional and Physical Trauma: The Effectiveness of a Weekly Craft Group - Linda Garner, PhD, RN, APHN-BC, CHES
Evaluating the Effect of Reiki on Stress, Anxiety, Pain and Depression among Persons living with HIV - Marie Bremner, RN, PhD

Effects of Reiki on Pain, Anxiety and Blood Pressure in Knee Replacement Patients - Ann Baldwin PhD, Anne Vitale, PhD APN AHN-BC, Elise Brownell, PhD and Elizabeth Kryak, MSN, RN-BC

Teaching Nurses Reiki Energy Therapy for Self-Care - Angela Brathovde, MSN, RN, BC, HNB-BC

AHNA Webinar on Preparing A Holistic Research Abstract: Think Success!

Preparing A Holistic Research Abstract: Think Success!
May 27, 2015 at 1 pm EST

If you plan to submit an abstract for an AHNA conference, this webinar is for you! This webinar will offer the participant an overview of the essential components for writing a successful research presentation or poster abstract. Examples of successful and unsuccessful abstracts will be provided to guide the participants through this process. Please bring individual ideas/exemplars for further discussion. Watch the AHNA Online Store for registration information.

Student Corner

My name is Sarah Stacey and I am a nurse practitioner student graduating this May as a Family Nurse Practitioner. I will be working at an Integrative Health center upon graduation. I plan to study functional medicine in the near future to gain the knowledge and skills needed to offer patients holistic care. While I was an RN student I realized how fundamental it was for professional nurses to care for themselves so they were available to physically, spiritually, and emotionally care for others. To address my own needs, I enrolled in a Mindfulness Based Stress Reduction (MBSR) course modeled after Jon Kabat-Zinn's work. I found it profoundly helpful as a tool and use it to deepen my compassion and my ability to care and authentically relate to myself and others. From this experience, I designed a pilot research project which will examine the effects of this same mindfulness course on the professional registered nurse. I am currently awaiting IRB approval. I will then look forward to starting the pilot research project in the fall. Themes planned for investigation are compassion satisfaction, resilience, burnout, compassion fatigue, and self-care habits both pre and post intervention. The end goal is to determine whether there is enough evidence to support the use of MBSR courses as an elective or better yet required course for undergraduate nurse degree completion programs. Or, as a wellness course offered by healthcare institutions to support the growth of RNs. If this pilot research project is successful and feasible, I am also interested in exploring how RNs who have taken a mindfulness course can impact patient safety and satisfaction.

Masters and Doctoral students are invited and encouraged to send abstracts of their thesis/dissertations/quality improvement projects and submit to Connections in Holistic Nursing Research for possible publication in the Student Corner. This gives students an opportunity to publish and allow others to gain interest in their work. If you are a mentor or advisor for a graduate student, please encourage them to share with us. Please send your submissions to
**Promoting Research and Quality Improvement in Holistic Nursing through Consultation Service**

**AHNA Research Consultation Service**

The AHNA Research Committee is now offering a program for those nurses who want to conduct research or are working on a quality improvement project, but need some guidance. If you are a new researcher who would like some assistance, the AHNA Research Consultation Program is for you.

For AHNA members, this service is provided for $20 for one research consultation and $50 for three, and can be purchased online at [www.ahna.org/shop](http://www.ahna.org/shop). Consultations are expected to be less than one hour, and will be most productive when the Consultation Request Form is thoughtfully completed. For example, providing your area of research interest and other descriptors will enable the program manager to better match you with a consultant. After purchasing your consultation service, you will receive an email receipt that guides you in the process for your consultation. This program is managed by Cindy Barrere, who can be contacted at cynthia.barrere@quinnipiac.edu.

The AHNA Research Committee is very excited to make this service available to the members, continuing their focus to promote and support future researchers in holistic nursing.

**A Call to Action for Research: Ghettoization in Healthcare: We Are More Than Our Disease**

The editors of Connections in Holistic Nursing Research are pleased to announce a new feature in our newsletter, "A Call to Action for Research". In this first article, Wendy Stivers discusses ghettoization of health care and how it has impacted her health.

We welcome others to submit suggestions for future articles. Please contact me at kingm@rmu.edu or michalene1@comcast.net with your ideas.

**Ghettoization in Healthcare: We Are More Than Our Disease**

*by Wendy Stiver, RN, CCM, BSN, MA*

**Introduction**

I live with rheumatoid arthritis (RA) and require treatment with methotrexate, a chemotherapy agent used in the treatment of many types of cancer. Although the dose of methotrexate I receive is lower than those given to cancer patients, I still experience similar side effects: hair loss, mouth sores, fatigue, alterations in taste and appetite, and “chemo brain.” I realized I needed some assistance with these side effects so I turned to a local support agency that provides wonderful programs and services for people on chemotherapy and other active forms of treatment. When I called to ask about a specific class, I was told I could not attend because I did not have cancer, and therefore was not eligible for their services. Despite being on a chemotherapeutic agent, despite my thinning hair and failing immune system, and despite my need for resources, I did not have the "right" diagnosis and thus was excluded from services. In a sense, I was forced into a health care ghetto based on my diagnosis rather than on what I wanted or needed.
Separate and not equal systems of care
It was this experience that launched my exploration of the literature on the topic of ghettoization of patients with their "own kind"; heart patients go to cardiac rehab and cardiology programs, COPD patients seek pulmonary support groups in local hospitals, and stroke patients often benefit from multidisciplinary rehab programs to help them optimize recovery. Cancer patients can access a world of disease specific programs, support services, magazines, inpatient hospitals, and outpatient clinics. Those of us with autoimmune diseases experience a fragmented system in which our damaged joints belong to rheumatology, our leaking guts to gastroenterology, our damaged hearts to cardiology, and so forth. I can get help from a multidisciplinary pain management program to help ease the pain, but have yet to find a place to go for skilled support and assistance with the myriad other symptoms that accompany both my disease and its treatment.

It is wonderful that a number of resources exist for people with cancer and it is very necessary. I am very appreciative of the assistance that my oncology patients have received over the years. It is wonderful that modern allopathic medicine can deliver specialized care for patients with complicated illnesses. It is not wonderful that we are identified by the label of our diseases, and placed in the designated ghetto.

What is a "ghetto," and how does this term apply to the lived experience of a person with an illness or disease in 2015?

History of a controversial word
Merriam Webster (n.d.) provides several meanings of "ghetto".
1. the quarter of a city in which members of a minority group live
2. an isolated group
3. a situation that resembles a ghetto especially in...limiting opportunity

While the word "ghetto" emerged in Italy in the 1500's, the definition that pertains to this discussion is an isolated group and a situation where isolation confers limited opportunity for a given group of people.

Stigmatization in Chronic Illness
Fennell (2003) points out that "stigma is attached to many chronic illnesses and that this has an adverse effect on the patient as well as those in the patient's world....Some conditions generally elicit sympathy and concern, whereas others arouse strong social condemnation and stigma" (pp. 2930). How does this explanation inform the construction of the health care ghetto? Do those diseases or conditions which elicit sympathy and concern also elicit more resources for supportive programs and services, as well as research into potential cures? Do the so-called "orphan diseases" and other less familiar conditions also receive less concern, less research money, and fewer resources for patients? For those with "invisible illnesses," there is the added dimension of living in a culture in which "we expect an obvious physical sign of illness or disability. Without such evidence, people can become suspicious and conclude that the person merely claims to be ill and may actually be lazy, malingering, and vaguely immoral" (Fennell, 2003, p. 29).
Proposed Vision of Needs Based Services Rather than Diagnosis Based
What if a cohort of patients experiencing fatigue could gather together for education, sharing, and support? What if the CHF patient could dialogue with the chemo patient and possibly share solutions to enhance quality of life? What if long term steroid users could join body image enhancement programs currently limited to those with cancer? In my opinion, the needs-based support services would be great and would require taking patients out of their diagnostic ghettos. I am not saying that diagnosis-specific programs are bad. I fully support specialty hospitals and organizations such as those for cancer and cardiac care due to the specialized technologies required for treating these diseases. I am saying that supportive services such as "Look Good, Feel Better"; "Twinges in the Hinges", and myriad other programs should be open to any patient who can benefit from attending, and has medical clearance to do so. Let us come out of our walled quarters and meet in the city square where we can learn from each other.

Call for Research
AHNA is an ideal environment for this topic to be explored. I am asking for holistic care for human beings based on what each person needs, regardless of the diagnosis or medications that cause that need. I am asking for a health care system in which we stop labelling if those labels exclude people from access to resources. I am asking for a health care system in which an RA patient like myself, with chemo brain, "chemo hair" and skin damaged from decades of prednisone can join a body image support and education program along with other patients on chemo where we can all learn from each other. I am more than a diagnosis, and I want to see the ghetto walls come down.

References


AHNA Researchers in Action

Full text available to AHNA members. Learn how.

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A variable is a measurable characteristic that varies among the subjects being studied. As the definition implies, the characteristic or phenomenon under study varies in some way.

**Independent Variable:** a stimulus or activity that is manipulated or varied by the researcher to create an effect on the dependent variable. It is helpful to remember the independent variable as the treatment or intervention.

**Dependent Variable:** the outcome or response that the researcher wants to predict or explain. Changes in the dependent variable are presumed to be caused by the independent variable. It is helpful to remember the dependent variable as the outcome being measured.

Example: "Cancer patients who receive music therapy have less perceived pain than cancer patients not receiving music therapy."

Music Therapy is the *independent* variable. Pain is the *dependent* variable.

Descriptive and correlational quantitative studies involve the investigation of research variables.

**Research Variable:** quality, property or characteristic identified in the research purpose and objectives or questions that are observed or measured in a study. Research variables are used when the intent of the study is to observe or measure variables as they exist in a natural setting without implementation of a treatment. Thus no independent variables are manipulated, and no cause-and-effect is examined.

**Extraneous Variable:** a variable that exists in all studies and can affect the measurement of study variables and the relationships among these variables. Researchers try to control for extraneous variables so they do not interfere with measurement and outcomes. One way is using inclusion and exclusion criteria when sampling.

**Confounding Variable:** a type of extraneous variable that is not recognized until the study is in process, or is recognized before the study is initiated but cannot be
controlled. Confounding variables weaken a study design and hinder interpretation of outcomes unless they are able to be controlled statistically during analysis.

**Environmental Variable:** a type of extraneous variable composing the setting in which the study is conducted. Examples of these include climate, family, healthcare system.

**Demographic Variable:** attributes of subjects that are collected to describe the sample such as age, gender, education, ethnicity, income, diagnosis, etc.

**Defining Variables**

**Conceptual Definition:** provides the theoretical meaning of a variable.

Example: Stress is defined by Lazarus and Folkman (1985) as a perceived state when demands exceed resources to manage those demands.

**Operational Definition:** provides the measurement process for the variable.

Example: Stress will be operationally defined using the Perceived Stress Scale.

**Resources**


*View AHNA's growing research glossary*. To contribute a definition or suggest a term, please contact research@ahna.org.
Although the AHNA supports the concepts of holism, it refrains from endorsing specific practitioners, organizations, products, services or modalities. Opinions expressed in this eNewsletter may not reflect the position of the AHNA.