Holistic Mental Health Nursing
The American Holistic Nurses Association (AHNA) is a non-profit organization whose membership is open to nurses and others interested in holistically oriented healthcare practices. Membership fees: $125/US, $55/Full Time Student, $80/Part Time Student, $75/Elder, $135/International.

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Beginnings...the awareness that all moments are in some way the start of another moment. AHNA is committed to learning and demonstrating the sacredness of all beginning.

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About the Cover Art
The mixed media artwork on the cover was designed by Victoria Gulino and is titled “Inner Sight.” A lifetime seeker, Victoria creates art as a portal to and expression of her transpersonal experiences and visions. When trust is given to the process, non-linear wisdom can germinate. Victoria is a licensed Mental Health Counselor, certified Transpersonal Coach, meditation and imagery teacher, and artist. She is on the faculty of the Huntington Meditation and Imagery Center (www.HuntingtonMeditation.com), where she assists in teaching the role art and imagery play in accessing inner resources. Expressive art and meditation are woven into her work as a path to self-discovery, transformation, and healing. Limited edition prints of her art work are available. Viki.Gulino@gmail.com
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Dorothy in the Wizard of Oz was told to “Follow the yellow brick road… follow the rainbow over the hill… follow the fellow who follows the dream… follow, follow, follow….” For Dorothy, the yellow brick road held promise and the right direction. AHNA’s Strategic Plan is our yellow brick road, which has been instrumental in guiding and advancing holistic nursing and holism within the healthcare system. We remain diligent and committed to staying aligned with the strategic plan. Below is an update on the association’s activities in 2016 that coincide with Goals 1-7 of the AHNA Strategic Plan.

**Goal 1. Increase AHNA Influence on Holism in Healthcare**

Our 2016 marketing strategy has included exhibiting at other healthcare-related conferences to promote holistic nursing and membership in AHNA. We negotiated a total of thirteen (13) conference partnerships and five (5) direct advertising exchanges in 2016. Two of the conference partnerships were specifically targeted to the Florida region to increase visibility for AHNA’s annual conference. We have carefully monitored geographic fluctuations in membership directly after exhibiting at these conferences and found slight increases to new memberships within some of these targeted locations. In 2017 and 2018, we plan to seek out partnerships for exhibiting at conferences that will be held prior to and in the same regions as the AHNA annual and regional conferences.

2016 completed partnerships included exhibiting at the following conferences:

- SCRIPPS – Natural Supplements Conference (San Diego, CA)
- Integrative Healthcare Symposium (New York, NY)
- 9th Evidence-based Complementary and Alternative Cancer Therapies Conference (Palm Beach, FL)
- Southwest Florida Sustainability Summit (Bonita Springs, FL)
- SCRIPPS – Integrative & Holistic Nursing Conference (San Diego, CA)
- Healing Touch Program World Wide Conference (Charlotte, NC)
- St. Anselm New England Holistic Nursing Conference (Kennebunkport, ME)
- Holos University Graduate Seminary – ISSSEEM Conference (Unity Village, MO)
- International Plant-Based Nutrition Healthcare Conference (Anaheim, CA)
- Healing Beyond Borders Annual Conference (Colorado Springs, CO)
- Traditional Chinese Medicine World Foundation’s Building Bridges Conference (Reston, VA)
- Southeast Wise Women’s Herbal Conference (Black Mountain, NC)
- American College of Nutrition 57th Annual Conference (San Diego, CA)

So far, we have negotiated partnerships to exhibit at the following conferences in 2017:

- SCRIPPS – 14th Annual Natural Supplements Conference (February 10-12, San Diego, CA)
- Integrative Healthcare Symposium (February 23-25, New York, NY)
- HealthCare Chaplaincy Network’s “Caring for the Human Spirit” Conference (March 13-15, Chicago, IL)

**Goal 2. Increase Communication, Education, and Awareness of Holistic Nursing and AHNA**

A new AHNA membership recruitment brochure was developed and printed for Chapter Leaders to use while exhibiting at venues. In 2016, we issued 60 press releases about relevant holistic nursing topics and AHNA programmatic activities, in comparison to 54 in 2015. AHNA’s redesigned website is scheduled for launch in January 2017 and will include a fresh, new look and responsive layout for mobile devices. Plus we plan to archive all historical press releases for easy access by the media.

AHNA’s Education Provider Committee (EPC) provided members with online and self-study CNE opportunities:

- Foundations of Holistic Nursing Course 5th Edition (90 participants)
- Journal of Holistic Nursing CNE (307 participants)
- Webinar CNE Listening/Credit (965 participants)
- Beginnings Free CNE (2,137 participants)

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Additionally, the AHNA 2016 Annual Conference in Bonita Springs, FL had 466 registered attendees and 88 different CNE offerings.

Jacob Wingard, AHNA Communications Coordinator, has been offering a social media webinar and private tutoring to help Chapter Leaders increase their local and regional presence through Facebook. AHNA staff also support social media from headquarters via content launches. Currently, AHNA's national Facebook page has 8,541 followers, with LinkedIn at 1,241 and Twitter at 833.

During the 2016 annual conference, AHNA hired a videographer, Evan Reser, to record video messages from members and elected officials. We have been able to use some of these messages in our recruitment campaigns, newsletters, and the re-designed website. Thank you to all who, when asked, participated in this project during the Florida conference and assisted with our 2016 digital messaging about AHNA and holistic nursing. Look for more opportunities to share your holistic nursing journey during the 2017 conference.

The 2017 Holistic Nursing Scope and Standards Task Force has completed the field review soliciting comments on the proposed 3rd Edition of the standards, which is in the final stages of being submitted in February 2017 to ANA for approval on behalf of the holistic nursing specialty. This is AHNA's essential obligation to the nursing profession.

**Goal 3. Enhance Financial Strength & Resources**
AHNA Treasurer Barry Gallison, DNP, MS, APRN-BC, NEA-BC provided an excellent overview of AHNA's financial status in the August 2016 Beginnings magazine, including long-term investments and the purchase of the building for national headquarters in Topeka, Kansas.

**Goal 4. Expand & Increase Awareness of Member Service Benefits**
AHNA sponsored three regional conferences in 2016: Charlotte, NC on March 18th (51 attendees), Mesa, AZ on November 4th (30 attendees) and Techny, IL on November 11th (53 attendees). We promoted these conferences via social media, print advertising, and brochures that were both locally mailed and electronically disseminated. Our goal is to host six regional conferences in 2017 due to the enthusiastic receptivity of local members who attended in 2016 and 2015.

Also in 2016, we re-designed the return on investment (ROI) card that is included with each membership renewal form sent in the mail. The ROI card lists the benefits of AHNA membership and is dually used as a handout for AHNA's exhibit tables.

The Practice Committee renamed the Community Building Calls to the Nurse Networking Calls. These calls occur three times per year and provide a facilitated opportunity for members to discuss relevant practice topics in a sharing and supportive fashion.

Chapter Leaders received The American Nurse video to offer 1.3 CNE contact hours at AHNA Chapter meetings. We supported several additional local activities for AHNA Chapters in 2016, including a National Women's Health Week initiative in conjunction with the HHS Office on Women's Health as well as a template for writing letters to the editor for local media outreach.

**Goal 5. Increase Membership**
AHNA's current membership count is 4,589 with a 74% retention rate. This compares to a 70% retention rate and 4,406 members at this same time in 2015. Seeking out lapsed members to return to AHNA has been a priority. AHNA staff ensure that Chapter Leaders have recruitment materials to share locally at meetings.

The Canadian Holistic Nurses Association (CHNA) has formally joined AHNA as our first international Chapter. We want CHNA to be strong and vibrant in Canada and are willing to assist them in achieving this goal. All current CHNA members are joining AHNA as international members and will enjoy the benefits of membership in both organizations. Past-President Peggy Burkhardt began this dialogue with CHNA in 2014, and President Carole Ann Drick has fostered this new relationship to offer their members greater return on investment by affiliating with AHNA for enhanced benefits.

**Goal 6. Strengthen AHNA Infrastructure**
AHNA hired Sharon Burch, MSN, APRN, CNS, APHN-BC, our first full-time Holistic Nurse Practice Specialist, in fall of 2016, raising the staff complement from 8.5 to 9.5 FTE (full-time equivalents) at the national office.

Launched in 2007, AHNA's current website is getting a redesign with fresh skin, more engaging buttons, and a responsive layout for mobile devices. The anticipated “go-live” date is in January 2017. The 454-page website has been combed through for accuracy and redundancy, and we have made adjustments to realign content for easy navigation.

**Goal 7. Increase Holistic & Integrative Research**
The Research Committee now has a total of 29 members, with 10 new members participating in 2016 and meetings held every other month. They completed an annotation of 182 holistic nursing research articles from the past five years to support the work of the 2017 Holistic Nursing Scope and Standards Task Force. Additionally, they are preparing to survey nurses in 2017 to examine the challenges of implementing energy healing modalities in U.S. hospitals and other healthcare organizations. Colleen Delaney, PhD, RN, AHN-BC represented AHNA at the HHS Patient-Centered Outcomes Research Institute (PCORI) nursing roundtable in the spring of 2016 and submitted a PCORI grant in May that includes AHNA as one of the partners.

2016 has been a productive year for AHNA. We credit our elected and appointed volunteers for accomplishing these strategic goals, increasing the recognition of holism within the healthcare arena, and bringing greater visibility to holistic nursing as a specialty practice. The AHNA staff is proud and eager to support this momentum as we look towards 2017 and the opportunities it holds.
Let’s think critically about mental health in our country and let’s be honest...brutally honest. Mental health issues and those who are affected by them are abundant, yet repeatedly overlooked, ignored, forgotten. Mental health services are under-funded, not supported by communities, and often considered a time-limited expense by insurance companies. Persons with chronic mental health issues are often shunned, made fun of, ignored, laughed at, and stereotyped by society. Mental health issues are not understood by society, and in many cases, not understood or nurtured by our caring profession. This is where holistic nurses can make a huge difference in their communities and their nursing practices.

There are people with mental health issues in every walk of life and every profession – everywhere we look. The range of mental health issues is varied, from minor to chronic. Holistic nurses in all care environments need to realize this and be ready to care for people with mental health challenges, acknowledging their feelings, considering their situations, and honoring their journeys. Holistic nurses are more aware and contemplative of how the trifecta of mind, body, and spirit works. They are prepared to take genuine, compassionate, and caring action as appropriate and not overlook, ignore, or shun these vulnerable persons.

Mental health nursing, in my opinion, is the responsibility of all nurses in today’s society. All nurses, but especially those who think and practice holistically, need to reach out to this underserved population, support them with caring, advocate for their healthcare needs in communities, and above all, educate society that mental illness is just like many other illnesses, and in many cases, can be treated with much success using traditional and complementary, holistic strategies.

Kathy Holloway, DNP, RN, PC, CNE, AHN-BC is a faculty member at Ameritech College of Healthcare in the Online RN-BSN program. Her professional interests include holistic nursing and mental health issues. Kathy lives in Ohio where she enjoys flower gardening, traveling, her three cats, and spending time with her husband and family.

How might the holistic nurse in any caring healthcare organization meet the needs of those with mental health issues or conditions?

✔ Accept each and every person unconditionally as a fellow human being.
✔ Look beyond their physical appearance.
✔ Assess their body language, nonverbal communication, and ask open-ended questions that relate to their story.
✔ If the person has chronic mental illness and is not able to answer questions or tell a story, just provide a safe, caring, calm environment for them where they are not frightened or at risk of being injured or injuring another person.
✔ In all cases, support them with a quiet voice, low stimulation, and just by being with them.
✔ Holistically assess the person’s needs by taking the time to really listen to their chief complaint, remembering that it may not be the real reason that they are seeking care.
Ten years ago, in December of 2006, I was nearing completion of my diploma program in nursing. The last day of class I was sitting among my peers when one of our professors came to congratulate us and ask which areas of nursing we planned to pursue. She asked by a show of hands. While the majority of my classmates raised their hands for critical care, medical-surgical, or labor and delivery, only one other person besides myself raised their hand when asked regarding mental health nursing. My professor, with an expression of expectation, then warmheartedly informed us that this was somewhat of a “trick question” and that each and every one of us was going into mental health. She continued that despite our various avenues of nursing, mental health will always be part of our patients’ overall health and well-being.

It has been almost a decade since I began working in a mental health emergency department (MHED). Much progress has been made even in this short time, such as the addition of social workers and peer-support specialists to our department. However, the risk of developing compassion fatigue continues to be an equally noticeable concern for mental health nurses. An unfortunate truth of the nursing role is the deemed “occupational hazard” of working with a population of patients that has a more common prevalence of traumatic history (Beck, 2011). High psychological resilience corresponds to a lower risk of developing compassion fatigue and burnout, and reinforcement of resilience can be supported through individual and organizational mindfulness, self-efficacy, and coping (Rees, Breen, Cusack, & Hegney, 2015). Mindfulness is thought to be the strongest predictor of burnout (Rees, et al., 2015). This is indicative that the crucial element to preventing compassion fatigue is intrapersonal intelligence, otherwise known as self-awareness or mindfulness.

What I have found of particular interest is that mindfulness is a universal need, both for ourselves in order to master our own lives, and also in pursuit of compassionate care to our patients. This is especially true if our intentions are undoubtedly to assist our patients in doing the same, mastering their lives. Mindfulness helps generate a presence of being and a state of non-judgement. The National Academies of Sciences, Engineering, and Medicine (NASEM) recently released a report indicating that a more collaborative effort needs to be taken to “reduce negative attitudes and behavior toward people with mental and substance use disorders;” they have stated that it is “among the most highly stigmatized health conditions in the United...
It is from this place of stillness that the components of our being can emerge, and we can manifest the highest version of ourselves; thereby encouraging our patients to do the same.

States” (NASEM, 2016). Often, it is this externalized stigma that tends to oppress individuals and keep those affected by mental health issues from making positive progress for their lives.

Mental health is multifaceted and requires nurses to look through a holistic lens to fully understand the manifestation of what we term mental illness. An individual and their mental health is an ambiguous integration of mind, body, and spirit with their surrounding environment (see box at right). Compton and Shim’s book, The Social Determinants of Mental Health, describes, unhesitatingly, the detrimental effects of: discrimination and social exclusion; adverse early life experiences; poor education; un/underemployment/job insecurity; income inequality, poverty, and neighborhood deprivation; poor access to healthy food; poor housing quality or housing instability; and poor access to health care. The authors contend that all these social determinants are “shaped by [a] multilevel distribution of money, power, and resources” (Shim et al., 2015, p. 4). Approximately half of Americans will be afflicted by some form of mental illness at some point in their lives (Shim et al., 2015). The effects of depression are central to the cause of disability and burden worldwide, and the most detrimental forms of mental illness, such as bipolar disorder and schizophrenia, are estimated at reducing the life expectancy of those affected by a monumental 25 years (Shim et al., 2015).

The implications for holistic mental health nursing are this: If we can begin to dismantle judgments within our minds and become more self-aware, then the attainment of both inner and outer peace is absolutely possible, and it could thereby generate a better state of individual as well as collective mental health. Unlimited potential and divine intelligence precedes thought. Thought precedes matter. Matter produces form, and form creates the experience of our reality. We need to tap into the space between this unlimited potential and thought in order to transform our presence. It is from this place of stillness that the components of our being can emerge, and we can manifest the highest version of ourselves; thereby encouraging our patients to do the same. An internal shift is a requisite of a shift among the physical world. We must begin from within.

REFERENCES


Brooke Johnson, RN, BSN, HNB-BC is currently a student in the Doctor of Nursing Practice Program at the University of Nebraska Medical Center (UNMC). Brooke also works in an electroconvulsive therapy treatment clinic (ECT Clinic). Her passion for expanding her education and consciousness has also led her to pursue Health and Wellness Nurse Coach board certification (HWNC-BC).

Mental Health: A Holistic Perspective

A person’s overall mental health is a product of many factors. Mental health evolves through continuous interaction which takes place on both the internal and external levels with regard to mind, body, and spiritual development, and is comprised of, but not limited to, the following:

- Brain functioning and chemicals
- Hormones
- Nutrition
- Immune system function
- Epigenetics
- Physical condition
- Environment
- Upbringing (nurture)
- Spirituality
- Social and emotional intelligence
- Interpersonal relationships
- Intrapersonal relationship with self and self-awareness
- Personality
- History of past traumas
- Subconscious programming
- Social determinants
Psyciatric 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 organismic, 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 psych-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.

continued on page 30
Holistic Approach to Care Augments the Mental Health Milieu

by DONNA LINETTE, DNP, RN, NEA-BC

The Behavioral Health Services at Broward Health Imperial Point (BHIP) in Fort Lauderdale consists of a 45-bed inpatient unit for crisis stabilization and an 8-bed psychiatric assessment area in the Emergency Department. As part of a small community hospital supporting holistic interventions, the Behavioral Health Services works closely with the nursing department to foster an environment of healing with an emphasis on caring relationships. The structure of the nursing department supports a shared governance model with many councils that determine practice and policy. One council, the Holistic Care Council is a front line committee that guides clinical practice relative to holistic approaches.

“The term ‘holistic’ means that the biological, psychosocial, spiritual, and cultural factors should be given equal consideration in crafting care and intervention” (Donnelly, 2011). This concept fits perfectly within the accepted model of mental health care today. The federal government’s Substance Abuse and Mental Health Services Administration (SAMHSA) defines Recovery as “A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential” (SAMHSA, 2012). SAMHSA lists ten guiding principles for supporting Recovery (Table 1), one of which is care provided should be holistic. Holistic recovery for those with a mental illness is really no different than holistic care in any other nursing specialty! SAMHSA’s working definition of “Recovery is holistic” recognizes the need for a comprehensive, multifaceted approach to mental health care:

Recovery encompasses an individual’s whole life, including, mind, body, spirit and community. This includes addressing: self-care practices, family, housing, employment, transportation, education, clinical treatment for mental disorders and substance use disorders, services and supports, primary healthcare, dental care, complementary and alternative services, faith, spirituality, creativity, social networks, and community participation. The array of services and supports available should be integrated and coordinated. (SAMHSA, 2012, p.5)

The Behavioral Health Services at BHIP has already incorporated Recovery as the model of care along with Jean Watson’s Theory of Human Caring as our theoretical foundation. Both serve and support the holistic framework throughout the hospital. Holistic care is offered through a variety of integrative approaches, including music, pet therapy, spiritual and group support, recreational therapy, and family/relationship support.

Behavioral Health Services at BHIP
The comprehensive Behavioral Health Services at BHIP includes: crisis stabilization, caring for both medical and psychiatric disorders, and assuring that appropriate follow-up is clear to the patient and family at the time of discharge. During the stay, groups and individual sessions provide the structure required for this very vulnerable population.

BHIP’s Behavioral Health Services is made up of a multidisciplinary team dedicated to providing compassionate, holistic care. Group discussions with our mental health counselors center on the value of meditation, yoga, and breathing exercises. The recreational therapists present exercise and other activities, such as music and artwork, assisting with care for mind, body, and spirit. Plus, the use of humor in the healing...
process is currently being explored by our certified therapeutic recreation specialists. Patient feedback has been positive, and this fits our goal of being able to provide therapeutic activities touching all in some way. Most recently, our registered nurses have been evaluating the use of aromatherapy as an intervention for anxiety in the psychiatric emergency department. This is already an active modality with demonstrated success on the post-op surgical floor (Gallison & Curtin, 2016). Behavioral Health Services is supported with a hospital-wide policy providing guidance for such interventions.

Throughout the day, activities and actions represent the Behavioral Health Services' holistic approach to practice. The day starts with an inspirational quote written on a white board at the unit entrance. The quote provides a moment of pause and a brief time to reflect. Whether viewed as spiritual, supportive, educational, or all three, this reflective pause sets the tone for the day for both patients and staff.

The Behavioral Health Services at BHIP uses music in a variety of ways. It provides time to relax and reflect. Music has an essential role in activity therapy, which is a necessary diversion in crisis stabilization. For our geriatric patients, background music is played during reminiscence group activities. It is also used at BHIP in karaoke groups to engage patients in positive, creative endeavors. Documented use of karaoke in mental health settings is limited. A study presented at the American Psychiatric Nurses Association’s 28th Annual Conference found that karaoke had a positive impact on anxiety (Brooks, 2014). Informal studies about karaoke at BHIP show it is a patient satisfier, and the staff has just received IRB approval to conduct a formal study in 2017.

Pet therapy is provided through an active relationship with the Humane Society of Broward County. Canine-assisted therapy has been well documented in the literature for mental health units, chemotherapy inpatient services, pediatrics, and heart failure patients (Snipelisky & Burton, 2014). Additionally, this intervention is offered hospital-wide to BHIP staff for stress management.

Spirituality is addressed during the patient admission assessment. Bibles are provided upon request, and spiritual group sessions are offered twice weekly and served by a lay ministry through Broward County Crime Commission. Spiritual care may be present in the group sessions, the daily quote, taking time to reflect, or religious services and observances.

In general, spirituality has been a much needed, yet under-supported modality in behavioral health. Often times in an acute environment, patients report delusions or hallucinations that are religious in nature, and for many years, the idea of adding a spiritual component to care was thought to be a mixed message about acknowledging delusions. It is time to move beyond this notion and assure care offerings meet a person’s individual needs. Jackson (2011) sums it up nicely by noting “We can all be effective spiritual care generalists simply by viewing all those in our care as spiritual beings. This means the atheist in our care is a spiritual being, as is the violently acting out client.”

Involving family and evaluating living arrangement options are challenging in short-term crisis situations. This avenue of support is essential as we know that structure and support in the community setting not only help to reduce length of stay in more restrictive (hospital) settings, but are also vital to long-term recovery. The key areas for assisting our patients in recovery include: relationships, support, and follow-up. All of these areas promote a holistic framework for clinical practice.

Mental health care on an inpatient unit requires an interdisciplinary team, and each team member’s role draws on concepts of holistic care to provide the recovery-oriented, holistic approach required for treatment today. Looking to the future, it is BHIP’s goal to continue to review and support the integration of holistic concepts in Behavioral Health Services.

**REFERENCES**


**Table 1. Principles of Recovery**

<table>
<thead>
<tr>
<th>Principle of Recovery</th>
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<tbody>
<tr>
<td>Recovery emerges from hope.</td>
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<tr>
<td>Recovery is person-driven.</td>
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<td>Recovery occurs via many pathways.</td>
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<td>Recovery is holistic.</td>
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<tr>
<td>Recovery is supported by peers and allies.</td>
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<td>Recovery is supported through relationship and social networks.</td>
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<td>Recovery is culturally-based and influenced.</td>
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<tr>
<td>Recovery is supported by addressing trauma.</td>
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<tr>
<td>Recovery involves individual, family, and community strengths and responsibilities.</td>
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<td>Recovery is based on respect.</td>
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Source: (SAMHSA, 2012)

**Donna Linette, DNP, RN, NEA-BC** is the Nurse Manager for Behavioral Health Services at Broward Health Imperial Point and adjunct faculty with the Christine E. Lynn College of Nursing at Florida Atlantic University. Her passions are leadership, caring, and continued lifelong learning. She can be reached at dlinette@browardhealth.org.
The Calling of a Mental Health Nurse: Preparing Students for Practice

by CHERYL A. PASSEL, RN, PhD, AHN-BC

I can still remember the apprehension I felt on clinical rotations during my first year of nursing school like it was yesterday. My classmates demonstrated enthusiasm to work with pediatric, critical care, maternal, and medical patients, but I found myself questioning, “Why did I enter into this major?” and “Am I cut out to be a nurse?” These questions were answered when I took my mental health course with a clinical rotation at a county facility in South Florida. My first days at the hospital, I encountered individuals with a multitude of mental illnesses ranging from major depression, addiction, personality disorders, and schizophrenia. I felt a sense of excitement and intrigue, not fear, like my classmates had expressed! At last, I had found my calling in nursing, and I began to spread the word to family, friends, and anyone that was willing to listen to me talk about mental illness. The majority of feedback I received was not encouraging: “Why would you want to work with those people?” “That is not real nursing,” and “You are going to lose all of your nursing skills.” I felt as if someone had ripped the carpet right out from under my feet, and I questioned if I should switch my focus to another area of nursing.

Upon graduation, I entered into an RN-BSN completion program with a philosophy focused on the concept of caring
and holistic nursing; this planted the seed to explore avenues for holistic healing in the psychiatric setting. Since then, I have been provided opportunities to work in many different settings and nursing roles, however, my heart has remained in mental health. Fast forward 25 years, I have been living my dream as a professor in an undergraduate nursing program. I teach mental health in the classroom and the clinical setting. Unfortunately, I have encountered the same stigma toward mental health as I did when I was a nursing student. Most students choose not to pursue careers in mental health for a variety of reasons, namely, “It’s too scary.” Then there’s the one that always hits a nerve, “Mental health nursing is not real nursing.” As a result of these responses, I have provided opportunities for students to explore their feelings through several modes of expression:

1. First, I have integrated yoga/meditation/breathing practices within the clinical/classroom setting. Yoga can lower anxiety, depression, and promote social function in nursing students (Yazdani, Esmaeilzadeh, Pahlavanzadeh, & Khaledi, 2014).

2. Second, students complete service-learning projects while providing six hours of service to vulnerable populations in mental health settings. Service-learning has been described as pedagogy that enables students to participate in learning experiences within the real world (Bailey, Carpenter, & Harrington, 2002). Service-learning provides students with opportunities to view caring from a new perspective and advocacy (Hunt, 2007).

3. Third, students are required to complete reflective journals prior to their first day in the mental health clinical. A reflective practice engages individuals in becoming self-aware while stimulating inquiry into the emotional self in the security of a safe environment (Freshwater, 2004). This practice requires the nursing educator to explore their own emotions and facilitate learning from a position of self-knowledge (Freshwater, 2004).

As a holistic nurse educator, I am aware of my unique role to cultivate caring, compassion, and self-awareness in nursing students and my community in order to promote healthy perspectives of mental illness.

REFERENCES:

Cheryl Passel, RN, PhD, AHN-BC is a holistic nurse with more than 25 years of clinical experience along with 10 years of teaching mental health nursing at Marian University in Fond du Lac, Wisconsin. She is a RYT 200 yoga instructor and provides stress management classes and yoga to students, faculty, and staff at Marian University as well as to the National Alliance on Mental Illness (NAMI) Brown County. She also teaches at several yoga studios in the Green Bay area.
Human beings are inherently vulnerable. Schaub (2016) defines vulnerability as “anxiety ultimately rooted in the human condition of being conscious, separate, and mortal. It is a normal emotion based in reality, an elemental aspect of our actual human situation” (p. 382). As we grow and mature in the world, we tend to nurture relationships with the people and confidants who have earned the right to hear our story (Brown, 2012). We share our struggles and worries with those who can bear the weight of our truth with dignity and acceptance. Many of us have a choice regarding who we trust, when we open up, and how we maintain authenticity throughout the course of such a bond. The willingness to share vulnerability with others implies risk without guarantees: courage in the presence of fear.

But there are those who do not enjoy the power of such choice: those who experience mental health challenges that predispose them to exposure and constant vulnerability on a momentary basis. Some battle severe mental disorders while others experience mild symptoms that go undiagnosed; many have experienced trauma. Holistic nurses and a holistic ethic of care provide the biopsychosocial support needed to embrace, guide, and effectively support these clients. From building individual partnerships…to creating healing dynamics at the group level…to transnational unitary efforts, we have an opportunity to effect change. Holistic practitioners carry with them the knowledge and skill to protect clients facing mental health challenges and ensure humanistic care on their behalf – from local to global.

The following are three case studies that illustrate my own observations of mental health and healing, as well as the lessons I have learned that reinforce holistic principles at a relational level.
CASE STUDY #1: INDIVIDUAL CONSIDERATIONS
During my undergraduate psychiatric rotation in nursing school, I spent time on an inpatient unit that cared for patients dealing with a host of mental health challenges. One day, I joined a woman sitting by herself in the corner of a room at a large round table. Laura had a warm smile on her face and graciously welcomed me. Having worked as a nurse in the earlier part of her career, she was overjoyed to meet nursing students. Laura had been on the unit for several weeks after she attempted suicide and was found by a friend. She talked about how kind the staff were and her gradual improvement. She inquired about my learning and the clinical experience. Throughout the conversation, she beamed with what appeared to be genuine happiness.

Suddenly tears filled Laura’s eyes and she grew quiet. As the energy shifted, she quickly became despondent, and eventually said, “You’ll have to excuse me. I have to go back to my room and find out why I keep thinking about killing myself.” Laura stood up and walked out of the room, and I grew overwhelmed by that novice feeling of confused helplessness. I later found out that Laura struggled with bipolar disorder.

Lessons Learned:
In retrospect, thinking of myself as a nursing student, I simply did not know how to hold the space for another person. A holistic nursing sensibility would have been quite helpful: It reminds us to remain open and nonjudgmental. It calls us to pause before we enter into a relationship so we can ground in both presence and intentionality. Back then I was too concerned about myself; my uninformed opinions about mental health challenges were unconsciously running my interaction with Laura, and I was intimidated by my own greenness. I did not understand what it meant to be truly open to another’s lifeworld – to stay available for the fluctuations of the human experience and support another throughout the spectrum of their emotional processing. If given the opportunity again, I would have listened more carefully to the clues Laura was offering about her change in mental outlook. I would have asked more reflective questions to help her manage the vulnerable moments. Laura taught me that I must be willing to confront and release my own fears in order to authentically guide another through theirs.

CASE STUDY #2: GROUP DYNAMICS
My cousin Jessica lives with schizophrenia. She was diagnosed as a teenager and has had a lifetime of voices and hallucinations that keep her from sleeping, eating, or carrying out many of the routine daily tasks most of us take for granted. Jessica’s treatment regimens were constantly being altered to keep up with her progressive symptoms, and it always seemed that more complex problems were arising from the side effects of polypharmacy. If the family was at dinner and Jessica started to hear voices, immediately, aunts, cousins, and grandparents would start yelling at them to go away. If she believed the bad guys were coming into the apartment through the secret door in the back of her sister’s closet, my mother would go in there and yell, loud enough for Jessica to hear, “Get out of this house before I call the police. Go! Good – get out!” She would come back and let Jessica know it was safe and that she could relax. Jessica would sit there comforted by the courage of her family and would often be able to enjoy herself again knowing she was deeply loved and cared for.

Lessons Learned:
Without realizing it at the time, my family was creating a healing environment by validating Jessica’s subjective experiences again and again. They did not question, reorient, or lose patience with her; they slowed down and responded to the more subtle requirements of the given moment. They were in a dynamic flow between what she needed and holistic attending. In essence, they worked together, as a team, to provide something beyond patient or person-centered care. They were delivering what has been called evolving human-centered care, defined by Rosa and Estes (2016) as:

...compassionate and empathic care that responds, attends, and conforms to the human as a living, breathing, evolving experience; human as a fluctuating phenomenological being of engagement; human as history, as story, and as narrative; human as presence, emergence, and possibility; human as fellow sojourner; human as caring-healing; and human as LOVE. (p. 336)

Many clinicians are hesitant to use the word love in describing the emotional bond with their patients. However, Goldin (2016) writes that nurses should not fear the power of love in the care we provide for patients, and she believes it to be the moral/ethical foundation of the profession. Love provides the tools and skills to embrace our clients’ mental health obstacles with both compassion and generosity.
Meditation and guided imagery are important components of holistic nursing. Guided imagery interventions have been researched and used with a wide variety of physical symptoms such as hypertension in pregnancy (Moffat, Hodnett, Esplen, & Watt-Watson, 2010), stress in hospitalized pregnant women (Jallo, Cozens, Smith, & Simpson, 2013), pain control in cancer care (Burhenn, Olausson, Villegas, & Kravits, 2014), and many other health challenges. In recent years there has also been extensive research on the beneficial effects of mindfulness-based meditation, including reduction in stress, anxiety, and depression (Rayan & Ahnad, 2016), chronic pain (Rosenweig et al., 2010), and chronic disease (Chan & Larson, 2015).

This article extends the clinical uses of meditation and imagery into issues that call for psychological healing in concert with physical treatment and healing. Stress has sources in a person’s present-day conflicts as well as past traumatic events (Husarewycz, El-Gabalawy, Logsetty, & Sareen, 2014); and clinical meditation and imagery methods have the potential to affect both of these dimensions of the human experience. This approach incorporates the generally accepted psychological truth that many of our patients’ present-day sensitivities are rooted in early life experiences and the meanings given to those experiences.

We developed the Images of Childhood Survey™ (Schaub & Schaub, 1997) to explore with patients both the past and present issues in need of healing.

The Images of Childhood Survey™ is filled with information. Having the client make notes allows for a sense of control while doing this exploration. In working with meditation and imagery practices, it is essential to communicate to the client that they have a choice to continue or stop at any point. We are not holding a set expectation of what should or shouldn’t happen. The client can stop at any time to process what has been experienced.

Examining each step of the survey, the first suggestion – imagine yourself
as a child – is open-ended. There are an infinite number of memories and images that could have presented themselves. Why did this particular childhood image come forward?

The client’s emotional reaction to the child is of particular significance. It is not unusual for someone to dislike the child. The client may be reacting negatively to reconnecting with the child’s vulnerability. Most reactions, however, are positive. In some cases, people who have not cried for years will open to the image and cry for the child. These tears are highly positive and a great source of self-compassion and healing.

The second image – the child at home – offers insight into the home environment and the nature of the relationships with family members. Are the people together and interacting? Are they off in different rooms, isolated from each other? This part of the imagery offers information to help enrich understanding of the child in the first image.

The third image – the child at school – gives you information about the child in the world. Is it a safe place? Does the child have friends and feel approved of by peers? Is school a place of feeling ashamed for not being smart enough, not feeling good about physical appearance, athletic ability, or not having the right clothes? School may have been a place where there was bullying.

The client’s memory of a teacher is also significant. Was the teacher a source of attention and affirmation? For some children, a teacher may be the only important adult in their life who acknowledged them and treated them with kindness and respect.

The fourth image – the child in a safe place – is often the most difficult image to connect with. The client may not have a memory of safety that readily emerges. This can be an upsetting realization. If a safe place is remembered, clients can use it to calm themselves down in difficult, present-day situations.

The fifth image – bringing the child into the present moment – introduces the possibility of healing. Turning toward the child with compassion and love will be an important step. If this step is difficult for the client, it becomes an opportunity for them to reflect on and learn from this insight.

A key component for the nurse in all of this is to listen and communicate interest, compassion, and calm. Many clients experience relief in the insights that emerge from this process. Their anxiety and other difficult feelings now “make sense.” They may have been judging themselves as “losers,” weak, or inadequate. Self-compassion becomes a new experience.

This approach extends the proven stress reduction benefits of meditation and imagery into areas of psychological insight and new mental-emotional growth. The reduction of physical tension and stress is enhanced when past mental-emotional injuries are given attention and care in the light of the present day.
Marina’s Journey – Using the Images of Childhood Survey™

A striking example of the effectiveness of the Images of Childhood Survey™ is seen in my work with Marina. She had been referred to me by a holistic nurse colleague who had been treating her for persistent pelvic pain. Marina was seeking holistic care because she had been unsuccessfully treated by several traditional practitioners and did not want to pursue any more tests or treatments with medication.

I started our work together by offering to teach Marina a very simple breathing practice for self-care. She agreed to learn the technique but didn’t want to close her eyes. Marina’s need to feel in control was apparent, and I experienced this as reflecting her vulnerability. I asked her to place her hands on her belly and just recognize the rise and fall of her abdomen with each breath, bringing her awareness back to her hands if she noticed her mind wandering. We did this for a few minutes, and Marina said it was “very relaxing.” I heard this response as reflecting her desire to please me, since it was such a brief time, and I could sense her effort to do it “right.”

Marina eventually settled into a schedule of meeting every other week. She usually spent the first half of the session reporting on how she was managing her pain and also what had happened at work since we last met. After several sessions, Marina seemed to be feeling safer. She had told me very little about herself other than she had emigrated here from Columbia at age 20 and had later brought her sister to New York where they were sharing a house. I mentioned this and asked if she would be willing to tell me more about her life.

Interestingly, Marina mentioned that my colleague who referred her had said that I work with imagery, which she was curious about. So, I decided to introduce the Images of Childhood Survey™ since Marina now felt safe enough to close her eyes during meditation. I like this exercise for introducing patients to imagery because they close their eyes briefly and then pause between images to take notes.

I reassured Marina that she would have complete control. The image she had of herself as a child was of a little girl playing with her big dog that she loved. She smiled as she described him. The image of herself at home was in the garden having a barbecue with her parents and sister. Marina seemed comfortable speaking of these memories. When I asked her to recall an image of herself in school, she became very still and was silent for a long time. After a while she began to cry, and I asked her what she was experiencing. She said she couldn’t talk about it and didn’t want to write anything. We sat quietly for a while, and I then asked her what she needed. She said she needed to tell me something she had never told anyone before. She was silent for few more minutes. Then she stopped crying and, told me her story rather matter-of-factly. In Columbia, when Marina was going to college, she would take the bus to school. Soldiers would always ask for everyone’s papers, especially all the students on the bus. It was very scary. One day Marina’s friend, a boy she had known for years, whispered to her that he didn’t have his papers. The two of them decided to run off the bus and get away. The soldiers chased after them, demanding that they stop. Suddenly a door opened on the narrow street they were running in. Someone pulled Marina in and quickly closed the door. It was just in time, because next she heard many gunshots and realized her friend was dead. I paused for a breath and took in the enormity of what I had just heard. This truly was the first time Marina had ever told this story. She didn’t know the woman who saved her. She never saw her again, but realized that this woman had risked her own life to save Marina’s.

She continued to work with me for several months. Sometimes Marina spoke of this event, and other times she spoke about details of her week. Her pelvic pain significantly diminished.

References

Bonney Gulino Schaub, RN, MS, PMH-CNS-BC, NC-BC is a master Clinical Meditation and Imagery teacher and practitioner. She is co-founder of the Huntington Meditation and Imagery Center. Most recently she has integrated this work into her Transpersonal Nurse Coach training program. Bonney is the author of Transpersonal Development: Cultivating the Human Resources of Peace, Wisdom, Purpose and Oneness.
Did you know we have sessions tailored specifically for nurses at the Integrative Healthcare Symposium Annual Conference?
CASE STUDY #3: POPULATIONS AT LARGE
This past year, I worked in Rwanda as a clinical educator at Rwanda Military Hospital and as a visiting faculty member at the University of Rwanda. The government of Rwanda reports that in 1994, the Genocide Against the Tutsi resulted in the deaths of roughly one million Tutsi and moderate Hutu people, and turned millions more into refugees and forcibly displaced peoples. The genocide was the epitome of human intolerance and “othering” – the result of decades of racially divisive tribalism and colonialist manipulation. The horrific events of 1994 affected millions: Rwandans living outside the country at the time, survivors who feared future aggression and had witnessed the murder of loved ones, and the perpetrators who now live with the atrocities they contributed to or committed themselves. Though Rwanda has known political peace since the late 1990s when all insurgencies were officially stopped, depression and post-traumatic stress continue to impact the population. A new generation is now living with the sequelae of institutionalized hatred and mass violence. Rwanda is a country experiencing a socioeconomic renaissance and continuing on the road toward unity and healing. Increased efforts are needed to attend to the mental health of the Rwandan people as health care in their nation experiences increased quality, access, and delivery.

Lessons Learned:
We are all healing from something, all seeking opportunities to make us whole and content. In Rwanda I found that every person I brushed shoulders with – from the man at the front desk at my gym to the woman in the marketplace – were all impacted by the brutality of genocide in some way. As holistic nurses, we must make room for people’s stories, invite the shadow side of their narratives, be channels for their progress and growth, and take care of ourselves so we can be of service in a real way. Self-care was the keystone to my well-being during my time in Rwanda; I simply could not have continued to provide the lovingkindness others needed if I didn’t learn to nourish it within my own life.

In conclusion, holistic nursing provides a human-centered approach to safe and inclusive care; it is the relationships we nurture with clients that provide the haven for expressed vulnerability. Learning to hold the space, create healing environments at all levels, invite client narratives, and take care of ourselves are all vital in the care of those experiencing mental health challenges. By being open to the process and suspending judgment, we become integral to the transformation of vulnerability from something feared into something cherished. Indeed, it is in that sacred threshold of the inherent human experience where healing becomes possible.

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William (Billy) Rosa, MS, RN, LMT, AHN-BC, AGPCNP-BC, CCRN-CMC, Caritas Coach, is currently a Palliative Medicine Fellow at Memorial Sloan Kettering Cancer Center in New York. He is editor of the book, Nurses as Leaders: Evolutionary Visions of Leadership, and his upcoming text, A New Era in Global Health: Nursing and the United Nations 2030 Sustainable Development Agenda will be released in May 2017. Billy is the recipient of numerous awards and honors, and is a Fellow of the New York Academy of Medicine.
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Applying Holistic Nursing in the Mental Health Setting

Can We Reach the Heart through the Feet?

by KATHY LEHMANN, EdD(c), RN-BC, PMHN and JANICE BRANDT, BSN

According to the authors of the American Psychiatric Association’s Task Force on Complementary and Alternative Medicine, effective integrative therapies can “expand the ‘toolbox’ of evidence-based therapies and engage more patients in treatment” (Freeman et al., 2010, p.678). In our facility, therapeutic foot massage is one such therapy used for clients with serious mental illness (SMI), who have lived in the hospital or supervised living facilities for extended periods. It used to be that toenail trimming for SMI clients was performed by a podiatrist during quarterly visits to our facility – orchestrated in military warehousing fashion while patients were seated in a large day room. The podiatrist went efficiently “down the line” to perform this care. When this podiatrist departed, permanently taking his leave, leadership made the decision to shift this care activity to nursing. One inpatient psychiatric unit embraced this concept to expand a
FOOT CARE & SMI CLIENTS

Clients with serious mental illness (SMI) often experience difficulty maintaining adequate personal hygiene practices. Although some receive personal care assistance, many live independently or in supervised group homes. Caring for their feet can be frequently overlooked, often until they are experiencing acute pain. Even then, they may be unaware of the cause of the pain. SMI clients often have a higher pain threshold than other populations and can present for foot care with an ulcer, avulsed toenail, severe onychomycosis, or even dislocated bones. According to the literature, massage therapy appears to be a safe intervention with low risk for adverse effects (Cavaye, 2012). By providing therapeutic foot massage to clients with SMI, they may experience decreased skin breakdown, increased circulation to the feet, and increased overall comfort.

In addition to providing physical benefits, therapeutic massage can be perceived as psychological therapy (Cavaye, 2012). It can aide in fostering trust and therapeutic communication between the nurse and SMI client. Physical touch is a form of nonverbal communication and is essential in the therapeutic care environment (Gleeson & Higgins, 2009). In a study by Kito and Suzuki (2016), the results of foot massage for clients diagnosed with residual schizophrenia “revealed that the patients accepted the nurses, who performed massages as not threatening but caring for them. It was probably because the patients sensed that the nurses paid attention to them, which led to their interactive relationship between them” (p.378).

SETTING THE STAGE

After the loss of our podiatrist, the hospital agreed to identify registered nurses who had previously received specialized training to provide foot and nail care. A podiatry Care Cart was developed for each unit and modeled after that used by the previous hospital podiatrist with an established procedure to follow infection control guidelines and regularly clean/replenish the cart’s equipment.

A specialized program was established to prepare additional nurses for this voluntary adjunct duty. The program is provided by our hospital’s education department at the request of interested nurses. Training is offered during work hours and incorporated into individual professional development plans. Core specialized training is five hours of online clinical education by Wound Ostomy Continence Nurse (WOCN) certified foot/nail care professionals. Training includes:

(a) anatomy and assessment of the foot and nail,
(b) common disorders and deformities of the foot and nail, and their current treatments,
(c) skin assessment,
(d) pressure ulcers of the foot, and
(e) proper nail shortening technique.

A supervising RNP/podiatrist completes a clinical competency skills set, which then authorizes them to perform autonomously in the role of a foot/nail care nurse.

These nurse specialists may advance to become Certified Foot Care Nurses (CFCN®). This credentialed process involves eight hours of clinical practicum supervised by a CFCN or podiatrist, and passing the foot care certification exam created by the Wound, Ostomy and Continence Nursing Certification Board. Our facility also offers annual continuing nursing education (CNE) contact hours to maintain clinical competency.

IDENTIFYING & CARING FOR CLIENTS

Foot and nail care by nurse specialists is provided to all clients of the inpatient medical and mental health units. A collaborative program expanded foot/nail care services by nurse specialists on the psychiatric units to SMI clients from affiliated Community Residential Care (CRC) homes during visits to the facility. Acknowledging that stigma can disrupt medical care for the SMI, the goal of this partnership was to provide routine foot care in a timely manner as well as to refer critical issues to outside podiatry providers. For example, diabetic clients deemed high-risk are treated only by a podiatrist, whereas others are offered nail trimming and foot massage by a nurse specialist who can reinforce diabetic foot care education during interventions. Clients with SMI who also have type II diabetes are at greater risk of developing pressure ulcers and other wounds related to acute injuries. Occasionally, clients will present with ulcers that they are unaware of. Urgent matters are fully assessed by the nurse specialist, appropriate wound care is provided, and the client’s primary care physician is alerted for medical follow up. The CRC social worker is also alerted to communicate with the outpatient client’s interdisciplinary team.

Clients with foot care needs beyond the nurse’s scope of practice are referred to their primary care physician; they may need an antifungal medication, prescription strength moisturizing lotion, or a surgical procedure. Clients are instructed to return in 2-3 months or as needed for routine care. Primary care physicians are briefed via forwarded progress notes, advised of any acute changes in baseline foot/toenail exam, and alerted of any needed prosthetic devices (inserts, shoes, socks, etc.). This interdisciplinary collaboration allows the client to receive the highest quality of care available.

OUTCOMES & BENEFITS

After regular participation in this program, the ward RNP noted a substantial reduction in the level of foot and toenail fungal infections being referred for treatment. Additionally, CRC clients required fewer referrals to an outside podiatrist, thus validating the cost effectiveness of the program. Another positive outcome is the consistency of clients returning to the nurse specialist for regular foot care. Clients reported that prior to the program’s initiation, they often attempted to trim their

continued on page 26
own toenails with poor outcomes; now, they prefer the nurse specialist perform their routine nail care because of familiarity with the hospital and positive rapport with staff. In addition, they report increased comfort after nail care and foot massage have been completed. Overall, clients experience improved foot/nail health and subsequent improved overall health. Moreover, the client load of the hospital podiatrist is reduced, and wait times for appointments are decreased. We enjoy a 100% participation rate in this program and are now incorporating the additional use of aromatherapy and hand massage into our milieu and program.

CHALLENGES & CONSIDERATIONS

Incorporation of therapeutic touch and massage with the SMI population can be challenging. Bonitz (2008) reminds us that the use of touch “despite its recognized therapeutic effects, has been highly controversial ever since Freudian times. Touch is a powerful means of nonverbal communication, capable of bringing about considerable healing effects . . . ; its use, however, is also associated with a potential for harm” (p.391). SMI clients may present as guarded and isolative or may be experiencing hallucinations, which can be exacerbated by being touched. Clients experiencing clinical depression may not respond positively to physical touch. While foot massage is performed using a moisturizing lotion, some clients may not like the sensation of lotion on their skin. They may also perceive the massage as intrusive or too intimate for their comfort. Keeping this in mind, verbal communication is especially essential when performing foot massage for clients with SMI. The nurse must request consent to perform the foot massage, and it must be completely voluntary and never forced upon the client.

Nursing assessment is critical to determine the best intervention when planning touch or massage. In their study of psychiatric nurses’ perceptions of physical touch, Gleeson and Higgins (2009) found that the nurses’ clinical judgement to use touch was based on individual client needs, as well as the nurses’ intuitive sense and awareness of the client’s verbal and non-verbal cues.

A CALL TO ACTION

This blended holistic mental health project was embraced by SMI clients, who readily identify the “foot care” nurses and seek their care. Traditionally, psychiatric nurses have been taught that they should touch their clients sparingly, if at all (Hilliard, 1995, p.29). Our experience demonstrates that trust, self-esteem, and relationships can be enhanced through the simple act of intentional physical touch. Even those individuals experiencing the highest levels of psychotic symptoms, most significantly paranoid ideations, responded positively, and continue to participate. This innovative program fills a need for SMI clients and remains viable. Having psychiatric nurses practice nail/foot care validates that holistic nursing practice is successful with SMI clients. We challenge today’s nurses in all settings to incorporate physical touch wherever possible to reach the heart of each client.

References


Kathleen Lehmann, EdD(c), RN-BC, PMHN has been a nurse for 39 years, blending psychiatry and holistic nursing in a variety of military and federal facilities. Her interest in holistic medicine began in Germany where she lived and worked for two decades. She served as co-chair of a hospital-wide integrative medicine committee introducing holistic concepts to staff and residents, and continues to incorporate these concepts into practice and teaching nursing students.

Janice Brandt, BSN has been a nurse for eight years, integrating holistic principles into psychiatric nursing in community hospital and federal facilities. Her nursing skills include foot and nail care, which she currently provides to clients living in community care homes as well as those on inpatient units. She has partnered with nursing professionals in developing programs to promote overall health in the psychiatric population, including foot, hand, and oral hygiene.

The contributors to this book write of their relationship with nursing; namely, what drew them to the profession and the circumstances and experiences that inspired their interest and passion.

In Part 1 of the book, well-known nurse leaders detail aspects of their professional contributions and the sensibilities that informed their actions. For example, in one chapter in this section, Lynn Keegan considers how to apply holistic nursing principles to end-of-life care. In another chapter, Donna M. Nickitas discusses the challenges and opportunities nurses encounter while advocating on behalf of patients, their families, and populations to improve their health.

In Part 2, brilliant and emerging contributors outline their scholarly and artistic approaches to the current status of nursing while pointing to the future direction for nurses and nursing. For example, A. Lynne Wagner examines the importance of storytelling and how it provides “a way to know and be known,” opening new possibilities for healing. Phalakshi Manjrekar discusses the importance of appreciating the contributions nurses can and do make toward establishing basic health amenities for all people in diverse cultural settings and those who speak many different languages (India alone, has approximately 1,721 spoken languages). Quite simply, nurses are in a position to bring about much needed, important changes in health care because they are closest to the point of care.

This book can serve as a primary text for undergraduate leadership and management courses as well as for graduate nursing administrative students. Questions at the end of each chapter provide fodder for discussion, promote reflection, and offer inspiration for all nurses to make contributions by serving as spokespersons and becoming involved in policy and advocacy work. Every nurse can and needs to be a leader.
Thank you to all members who voted in the AHNA Elections. The AHNA Elections Results Being Tallied. Thank you for Voting.

Information from the survey results will be compiled and shared needs related to the implementation of energy healing modalities across the United States, the AHNA Research Committee is developing a survey. By gathering information from registered nurses across the United States, the AHNA Energy Healing Modality Survey to be conducted in January 2017. In order to better identify the challenges of registered nurses seeking to implement energy healing modalities within hospitals, the AHNA Research Committee is developing a survey. By gathering information from registered nurses across the United States, the AHNA hopes to determine the barriers, prevalence, and learning needs related to the implementation of energy healing modalities for patients in clinical practice within healthcare institutions.

The announcement of those elected will be published in the e-newsletter and tallied due to post-marking. The Tellers Committee Report and announcement of those elected will be published in the e-newsletter and in the next Beginnings magazine.

AHNA Staff Welcomes Holistic Nurse Practice Specialist: Sharon Burch

Please join in welcoming Sharon Burch, MSN, APRN, CNS, APHN-BC as the newest member of the AHNA staff. Sharon will assume responsibilities in the areas of practice, continuing education, and program coordination for AHNA's growing outreach regionally and nationally. Sharon is a holistic health educator, advocate, and clinical nurse specialist with more than 40 years of experience in: hospitals, nursing homes, home health care, and hospice; massage therapy, nutritional coaching, and shamanic healing; and holistic nurse entrepreneurship, business administration, and management. She has authored two textbooks for massage therapists and bodyworkers: Recognizing Health and Illness and Holistic Pathology for Body-Centered Therapists. She has also authored more than 40 home study continuing education courses for holistic nurses, massage therapists, and bodyworkers, including: Helping Clients Manage Chronic Pain and Holistic Self-Care for the Caregiver.

Sharon first became a nurse in 1974 when she graduated from a licensed practical nursing program in Indianapolis, IN. She obtained both her ADN and BSN from the University of New York, Regents External Degree Program in the 1980s, followed by an MSN in Community Health Nursing from Wichita State University in 1993.

Sharon volunteers as a business advisor to the Hawaii Yoga Institute. In her free time, she enjoys spending time with her daughter, 39, and coaching family caregivers who are also business owners.

AHNA Energy Healing Modality Survey to be conducted in January 2017

In order to better identify the challenges of registered nurses seeking to implement energy healing modalities within hospitals, the AHNA Research Committee is developing a survey. By gathering information from registered nurses across the United States, AHNA hopes to determine the barriers, prevalence, and learning needs related to the implementation of energy healing modalities for patients in clinical practice within healthcare institutions. Information from the survey results will be compiled and shared with AHNA members and non-members as an initial step towards providing necessary resources for the implementation of energy healing modalities within healthcare institutions.

AHNA Elections Results Being Tallied. Thank You for Voting

Thank you to all members who voted in the AHNA Elections. The
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KEYNOTE PRESENTERS:
Andrew Weil MD
Integrative Nursing and the Wisdom of Collective Experience

Jean Watson PhD, RN, FAAN
Caring Science and Integrative Nursing: An Evolving Foundation for the Discipline of Nursing

Billy Rosa, MS, RN, LMT, AHN-BC, AGPCNP-BC, CCRN-CMC
Taming the Mad Elephants: A Beginner’s Guide to Compassion
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 green and 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.

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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


Nurse Practice Act (NPA) Analysis Summary December 2016

Background
In 2011-2012, the AHNA Practice Committee initiated a project to provide a specific state-by-state analysis of Nurse Practice Acts (NPA) that referenced or addressed holistic nursing, holism and/or complementary alternative modalities (CAM) or integrative therapies within the scope of practice of registered nurses (RNs). The initial analysis was prepared by Rebecca Cohen, EdD, RN, MS, MPA, HNB-BC with assistance from intern Sophia Bergum. In the summers of 2013, 2014, and 2015, Sarah Schneider, originally an intern from Rogers State University in Oklahoma, contacted every Board of Nursing (BON) to verify and obtain updated information about NPA language changes pertaining to holistic nursing, holism, and CAM, as well as position statement adoption by the BON that addressed any aspect of these. In 2015, Tabetha Schoenfeld, AHNA staff, contacted every BON.

2016 Nurse Practice Act Analysis
This report is the 2016 summary of U.S. BONs in all 50 states and six jurisdictions licensing RNs, including Washington, DC. The AHNA website contains a listing of all the BONs and their respective websites and contact information, as well as the specific references listed in this report. These have been updated with relevant references and can be found at www.ahna.org/Resources/Publications/State-Practice-Acts.

Since AHNA’s last NPA analysis in 2015, Kentucky issued an Advisory Opinion on Acupuncture: “The performance of acupuncture is within the scope of advanced practice registered nursing practice for the APRN who is currently educationally prepared and clinically competent in the performance of the procedure.” Further, the APRN should maintain documentation of having completed a nationally recognized course of study in acupuncture. The performance of acupuncture should be in accordance with documented facility policy and procedures and credentialing processes, as well as current evidence-based practice. Vermont updated references in their current position statements to reflect the name change of the National Center for Complementary and Alternative Medicine (NCCAM) to the National Center for Complementary and Integrative Health (NCCIH).

Four states have direct references in their respective Nurse Practice Acts that mention holism/holistic as defined or that recognize holistic nursing as a specialty (II, NV, OR, TX). Seventeen states incorporated references and/or position statements separate from their Nurse Practice Acts on holism/holistic treatments or CAM (also referred to as Complementary Integrative Health Approaches). Not all BONs are authorized to adopt position statements.

The following is a summary of AHNA’s findings for the 17 states that incorporated holistic-related references:

- All complementary/alternative therapies (AR, FL, MN, NC, CA, ND, NY, TX, VT)
- Hypnotherapy, dietary supplements, food additives, homeopathic remedies, or massage (AK, MA, VT)
- The role of nurses in businesses offering complementary/ alternative or holistic practices (KY, LA, MA, NH, NV, PN, TX, VT)
- Specific procedures and guidelines (ME, KY)

This project is ongoing, and AHNA contacts each state BON at least once annually. The following information has been revealed since our initial analysis:

- Kentucky adopted an Advisory Opinion authorizing APRNs who have been formally educated to perform acupuncture.
- Massachusetts revised their advisory ruling number 9801 in 2015 for the scope of practice for RNs and LPNs on holistic nursing and the incorporation of complementary integrative health approaches (CHA).
- California adopted a position statement in 2000 about holistic nursing titled “Complementary and Alternative Therapies in Registered Nursing Practice.”
- The New Hampshire BON recognizes alternative therapies as something that RNs can perform.
- Pennsylvania has a construct from 1997 titled “Alternative/ Complementary Therapies” about evaluating when to “undertake” alternative therapies.
- Florida has a section of Chapter 456 that pertains entirely to alternative healthcare treatments by RNs.
- Texas revised its position statement 15.23 “The Use of Complementary Modalities by the LVN or RN” in January of 2013, which contains specific mention of CAM as long as the proper credentials (e.g. license, certification, registration) are held to safely engage in specific practices where applicable.
- New York has practice information on CAM, titled “Complementary/Alternative Medicine/Therapies [CAM].”
- North Dakota has a broad definition of nursing, encompassing holistic nursing and CAM, as well as a specific practice statement titled “Complementary and Alternative Therapies.”
- Vermont has position statements titled “The Role of the Nurse in the Administration of Homeopathic Drugs, Herbal Medicine Products, and Dietary Supplements,” and “Responsibilities of the Nurse in Providing Complementary and Integrative Health Interventions.” In 2016 the term NCCAM was replaced with NCCIH.
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- Ann Baker, BSN, MPH - NIWH Graduate

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- Judith Brinn, BS, CHHC, Obesity cert. - NIWH Graduate

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AHNA Beginnings Schedule
February 2017
Art & Aesthetics in Nursing
Article Deadline ............... November 15
Mail Date .................. February 2017

April 2017
21st Century Holistic Nursing: Re-Shaping
Health and Wellness
Article Deadline .............. January 16
Mail Date .................. April 2017

June 2017
Emotional Health & Wellbeing
Article Deadline .............. March 15
Mail Date .................. June 2017

August 2017
Holistic Pain Management for Nurses
Article Deadline .............. May 15
Mail Date .................. August 2017

21st Century Holistic Nursing:
RESHAPING
Health & Wellness
American Holistic Nurses Association
37th Annual Conference • June 5 – 10th, 2017
Westin Mission Hills Resort & Spa
Rancho Mirage, CA