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# Faith Community Nursing: Providing Appropriate Clinical/Pastoral Response Regarding Complementary Medicine Therapies

Rosanne Bell Rechlin

# FAITH COMMUNITY NURSING:

# PROVIDING APPROPRIATE CLINICAL/PASTORAL RESPONSE REGARDING COMPLEMENTARY MEDICINE THERAPIES

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## Abstract

The specialty practice of *Faith Community Nursing* merges professional nursing and spiritual care expertise. Faith community nurses work within a faith community to promote wholistic health and prevention or minimization of illness, focusing on the intentional care of the spirit. Congregants may approach a faith community nurse for consultation regarding complementary medicine therapies, practices done in combination with Western medical practices. Twenty faith community nurses participated in a semi-structured interview to describe the process used to assess the value of a complementary modality and eight specific therapies.

To address a complementary medicine therapy, the faith community nurses consistently used the same process as they used with Western medicine practices, the nursing process model. To evaluate scientific support, a variety of sources were used. With respect to spiritual ramifications of a practice, the nurses relied more frequently on the guidance of a pastor or congregational expectations verses use of denominational or congregational documents.

Coalescing the nursing process with an adaptation of *Four Topics*, a clinical decision model developed by Albert R. Jonsen, Mark Siegler, and William J. Winslade, a proposed praxis was presented. The praxis supported the autonomous and ethical practice for navigation of decision making with respect to complementary medicine practices as required by *Faith Community Nursing Scope and Standards of Practice,* and the American Nurses Association *Code of Ethics for Nurses with Interpretive Statements.*

The complementary therapy models explored were used to test the praxis. Acupuncture, biofeedback, reflexology, and tai chi were found to be generally safe. Hand-medicated practices could be supported for benefits of relaxation. Yoga could be supported as exercise, but the philosophical underpinnings of the yoga practice should be understood. While Reiki did not seem to be potentially physically harmful, its lack of scientific support and potential for spiritual confusion led to a recommendation of non-use. The belief in the effectiveness of prayer countered the inconsistent scientific data responses.

A praxis offers a model for general use. Individual recommendations for support or refute of a complementary practice are dependent on the specifics of the situation, client goals, and client preferences.

# Chapter 1

## Introduction

### Statement of Pastoral Concern

Congregants approach faith community nurses for advice concerning complementary medicine therapies. The term *faith community nurse* designates a registered nurse, specializing in faith community nursing, knowledgeable in both professional nursing and spiritual care.[1] For the purposes of this thesis-project, the definition of complementary medicine therapy is therapy that is used as an adjunct to an established conventional medical treatment plan. Examples of complementary medicine therapies include, but are not limited to, acupuncture, aromatherapy, hypnosis, reflexology, Reiki, and Tai chi. This definition of complementary medicine contrasts the definition of alternative medicine practices, those used in lieu of conventional medical treatments. For instance, cobra and other snake venoms have been used to treat a variety of illnesses such as muscular dystrophy and multiple sclerosis, instead of the standard conventional treatments. Conventional therapies are associated with medical physicians, hospitals, and modern Western health care system which include use of pharmaceuticals, surgery, technology, and physical devices to prevent diagnose, treat, and cure disease.[2]

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[1] *Faith Community Nursing: Scope and Standards* (Silver Spring, MD: American Nurses Association, 2012), 5.

[2] Dónal O'Mathúna and Walt Larimore, *Alternative Medicine: The Christian Handbook* (Grand Rapids, MI: Zondervan, 2007), 29. Opher Caspi, Lee Sechrest, Howard C. Pitluk, Carter L Marshall, Iris R. Bell, and Mark Nichter, "On the Definition of Complementary, Alternative, and Integrative Medicine: Societal Mega-stereotypes VS. the Patient's Perspectives," *Alternative Therapies* 9, no. 6 (November/December 2003): 58.

The ministerial focus of this project concerns how faith community nurses address queries from parishioners regarding the use of a complementary medicine therapy.

### Ministerial question

What process, which is both evidence based and theologically consistent with the Roman Catholic faith traditions, should be used by faith community nurses to determine an ethical response to affirm or refute a particular complementary medicine therapy when approached by a congregant?

## Description of Ministerial Concern

### Description of Current Ministerial Practice

I am one of approximately 15,000-20,000 faith community nurses in the United States.[3] My part-time practice is situated within a Roman Catholic Church in Southwest Florida, with approximately 3,500 families. The nursing specialty of faith community nursing is defined as a non-denominational "specialized practice of professional nursing that focuses on the intentional care of the spirit as well as on the promotion of wholistic[4]

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[3] Maureen Daniels, Faith Community Nurse Specialist at the International Parish Nurse Resource Center projected 15,000 based on the number of faith community nurses that have been trained in the specialty practice. However, she added that there is currently no way to accurately count those that are practicing this specialty. At the Westberg Symposium April 7-10, 2016, sponsored by the Church Health Center of Memphis, 15,000-20,000 worldwide faith community nurses was the estimate provided.

[44] Kathy Schoonover-Shoffner presents the challenge of differentiating the usage of the terms "holistic" and "wholistic." Although a review of literature exposes the use of both terms by authors to mean the same thing, Schoonover-Shoffner defines "holistic" as an alternative therapy view which sees the body as an impersonal dynamic energy field that can be manipulated. Holism refers to the idea that the whole is

health and prevention or minimization of illness within the context of a faith community."[5]

Parishioners seek the expertise of the faith community nurse for a variety of reasons. For example:

- a parishioner may have a health concern and/or request a professional referral
- a parishioner may have questions regarding an increased level of care
- a parishioner may have a question regarding a diagnosis or treatment plan
- a parishioner may query as to whether alternate treatment plans exist

Parishioners may also approach a faith community nurse about the benefits and contraindications of complementary medicine approaches. For example, parishioners may have read or heard about a therapy from an acquaintance or through mass media and may want to know if there is "something more can be done," given a particular situation.

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more than just the sum of the parts, the parts both interacting and are interdependence. "Wholistic" is the term used by to describe an individual as an integrated biopsychosocial spiritual being created to live in relationship with God and others. In wholism, all parts are addressed simultaneously. The American Nurses Association and American Holistic Nurses Association identifies the professional nursing term which refers to the integrated whole person care is "holisitic." (Kathy Schoonover-Shoffner, "Think About It: Holistic or Wholistic?" *Journal of Christian Nursing* 30, no. 3 (July-September 2013): 133. The preferred spelling for the care provided by faith community nurses is "wholistic." Deborah J. Ziebarth and Katora P. Campbell, "A Transitional Care Model: Using Faith Community Nurses, *Journal of Christian Nursing* 33, no. 2 (April-June 2016): 114.

[5]*Faith Community Nursing: Scope and Standards*, 5.

## Bridging Science and Theology

Faith community nursing has the unique position of bridging science and theology. As a professional nurse, the faith community nurse is accountable to professional nursing standards and uses evidence-based practice in providing care to individuals. Specific interventions are employed by faith community nurses, and the focus of this thesis-project is most closely associated with the interventions of client advocacy, health teaching and health promotion, and client referral. These three interventions require that the faith community nurse be familiar with a variety of health topics and available local resources.

The term advocacy is defined as speaking on behalf of another, and health advocacy is a key intervention for the faith community nurse. The faith community nurse "promotes, advocates for, and strives to protect the health, safety, and rights of the patient."[6] Advocacy activities vary. For instance, a faith community nurse may advocate for a client to receive an appropriate level of care, or may serve as an advocate for those with limited resources. In certain situations, a faith community nurse may accompany an individual to a health care provider in the role of an advocate.

The activities of health promotion and disease prevention are core to the practice of faith community nursing and these are often accomplished through the provision of information that supports optimal health and decreases health risks.[7] Health instruction

[6] *Faith Community Nursing: Scope and Standards*, 10.

[7] Myrna Harris Cassimere, "Health Promotion," *Faith Community Nursing Education Foundations of Faith Community Nursing Curriculum*, (Memphis, TN: Church Health Center), 4.

may include topics such as healthy lifestyles, risk reducing behaviors, disease prevention, the body-mind-spirit connection, and spiritual practices for health and healing.[8]

It may be necessary to refer a client to another provider, should the client's needs be outside the scope or expertise of the faith community nurse. Referral may be defined as the process that guides or directs an individual to a resource or service. It is the obligation of the faith community nurse to have knowledge of resources, both within the faith community and in the broader community, is necessary to facilitate appropriate resources. Included in resource assessment by the faith community nurse are the tasks of educating and empowering the faith community in the use of the resources.[9]

Working within the context of a faith community, the faith community nurse's practice is also permeated with the principles and rituals of the particular faith community. It is incumbent upon the nurse that interventions used by the faith community nurse are consistent with the precepts of that particular faith tradition.

Standards provide a framework to guide decision making, but cannot provide answers for all situations. While the disciplines of science and theology often complement each other, this is not always the case. The faith community nurse may be challenged when a decision is to be made and a tension between the guiding principles of the two disciplines exists.

Although a faith community nurse may belong to a network of other faith community nurses, often faith community nurses are single practitioners within

[8] *Faith Community Nursing: Scope and Standards*, 29.

[9] Judith Mouch, "Assessing Resources," *Faith Community Nursing Education Foundations of Faith Community Nursing Curriculum*, (Memphis, TN: Church Health Center), 2.

congregations. While he/she has pastoral colleagues, the faith community nurse may be the only nursing professional, and only professional licensed by the state to perform a function. While some Christian denominations provide directives for some situations;[10] guides cannot span all situations. Other faith traditions do not offer formal guidelines. In other faith traditions faith community nurses may have the direction of a senior pastor; others are left to navigate "pop culture," the literature, and religious implications independently.

The impetus for this thesis project was the diversity of considerations which affect the decision making process for faith community nurses. This often solo practice leaves the nurse to negotiate concerns of science, nursing, theology, the faith community, and the individual. This thesis-project is designed to illuminate a process to be used by faith community nurses to provide an ethical response, to questions without known answers with respect to regarding complementary medicine therapies.

As this thesis-project will be done from a Roman Catholic faith community nurse perspective, the primary audience for this project will be Roman Catholic faith community nurses. However, a secondary audience is faith community nurses from main-line Christian denominations who are approached by their congregants with inquiries regarding complementary medicine approaches. It is recognized that although resources used for the ethical decision making process by Roman Catholics are not binding to non-Roman Catholics they may still contribute guidance to other Christian communities. Additionally, it is hoped that the methods used to ascertain that

[10] For example, the United States Conference of Catholic Bishops Committee on Doctrine developed *Guidelines for Evaluating Reiki as an Alternative Therapy*, which was introduced on March 25, 2009.

recommendations are clinically appropriate and consistent with the Roman Catholic faith tradition can be used as a guide across other Christian faith traditions.

## Significance of Ministerial Concern

The philosophy of integrative medicine is changing the landscape of medical systems in the United States. In many cases there has been a shift from a concentration on healing the sick to focusing on the promotion of wellness. At the same time, the relationship between physician and patient is also shifting. What was once an almost universal experience of a patient going to a physician and doing whatever the physician said without question has changed. Many patients are smarter with respect to health issues and more involved consumers of medical care. Patients often demonstrate a more active engagement in their treatment plans, both researching and questioning advice received from their physician or health care practitioner.

Complementary therapies are popular in today's Western society, and parishioners may both question the efficacy of a particular complementary therapy as well as voice concerns regarding the spiritual implications of the complementary therapy. Faith community nurses may be approached by congregants for advice concerning complementary medicine therapies and there may be no standard answer available. Complementary medicine therapies encompass a range of therapies that enjoy varying levels of acceptance from different sides. The medical community evaluates complementary medicine therapy practices, and some faith communities offer critique of such therapies. However, the evaluations of therapies may be inconsistent within both

medical and faith communities. These dichotomies can make it difficult for a faith community nurse to render an opinion with respect to the use of complementary medicine therapies.

Conventional medicine therapies are those therapies associated with medical physicians, hospitals, and the modern Western health care system.[11] As previously mentioned, for this project *complementary medicine therapy* is therapy that is used as an adjunct to an established conventional medical treatment plan. An example might be the use of acupuncture to treat nausea and vomiting following chemotherapy infusion. Conversely, *alternative medicine therapies*, which will not be addressed in this thesis-project, are defined as those therapies that are used as an alternative to conventional medical practices,[12] for instance, the use of Noni Juice or mushroom tea to treat cancer instead of usual and customary options.

Engaging in the fields of science and theology, faith community nurses must be responsible to both. As a registered nurse, the faith community nurse follows the nursing process which includes assessing the individual based on the collection of objective and subjective data, establishing a nursing diagnosis, identifying outcomes and a plan that prescribes strategies and alternatives to attain the outcomes, implementing the plans, and evaluating the progress towards the attainment of outcomes.[13] The faith community nurse is charged with the obligation to integrate evidence based nursing knowledge and

[11] See page one for definitions of conventional, complementary, and alternative medications, O'Mathúna and Larimore, 9.

[12] Caspi, et. al., 58.

[13] *Faith Community Nursing: Scope and Standards*, 19, 21, 22, 24, 26, 33.

use research findings to guide practice.[14] Additionally, strategies that are used for outcome accomplishment are to be safe, effective, and financially responsible.[15]

In addition to following the discipline of professional nursing, faith community nurses also serve as a member of an inter-professional staff within a particular faith community, providing care for the community as a whole, as well as particular groups and members of the faith community.[16] The faith community nurse must practice ethically. This involves care delivery which preserves the client's autonomy, dignity, rights, spiritual beliefs, and spiritual practices.[17] An ethical opinion must be offered a parishioner formed within the boundaries of science and faith based tenets.

There is a broad range of complementary medicine practices and these approaches have varied levels of controversy. The upsurge of complementary and alternative medicine has increased an awareness of religion and spirituality within the medical field, and spiritual practices have become included in the spectrum of complementary and alternative practices. For instance, prayer for health reasons was one of the most frequently cited complementary therapies practiced in the United States.[18]

Complementary practices and practitioners may offer touch-intensive, humane, and compassionate care. This type of care can present a stark contrast to the experience often presented by depersonalized allopathic medicine mode, the focus of which is disease remedies.[19] A possible negative consequence is practitioners may take advantage

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[14] Ibid., 39.

[15] Ibid., 49.

[16] Joe E. Trull and James E. Carter, *Ministerial Ethics: Moral Formation for Church Leaders* (Grand Rapids: MI: Baker Academic, 2004), 14.

[17] Ibid., 35.

[18] Ibid.

[19] Harold G. Koenig, Dana E King, and Verna Benner Carson, *Handbook of Religion and Health*, 2nd ed. (New York: Oxford University Press, 2012), 6.

of vulnerable individuals and lure them to unproven complementary approaches which lead to out of pocket and unreimbursed expenses.

Resources have been developed to guide religious professionals and non-professionals in the use of complementary medicine practices. For instance, the Christian Medical Association commissioned *Alternative Medicine: The Christian Handbook*, which is designed to combine the latest and most accurate information regarding alternative medicine from both the science and Judeo-Christian world view.[20] Carrie M. Dameron, the author of an article that first drew my attention to this issue, cited this source, stating with respect to Reiki, Therapeutic Touch, and other spiritual practices, "In general, Christians should completely avoid energy medicine."[21] While this might provide some guidance to a faith community nurse, the assessment also implies there may be times when sound judgement would actually recommend the use of energy medicine.

Ambiguity exists, and the faith community nurse is ultimately left to discern an ethical response. As a nurse, I am obligated to use evidence-based practice. As a Roman Catholic working within a Roman Catholic faith community, I am obligated to follow the doctrines set forth in the Roman Catholic faith tradition. As a pastoral minister, I want to do the best for the individual with whom I am working. As a Christian, I am obligated to form and follow my formed conscience. How do faith community nurses honor these obligations to provide the best care for congregants seeking information? To address this ministerial concern, the purpose of thesis-project is determine and assess the methods used by faith community nurses to respond to inquiries with respect to complementary

[20] O'Mathúna and Larimore, 14.

[21] Carrie M Dameron, "Energy Therapies in Christian Nursing? Part 2." *Journal of Christian Nursing* 30, no. 4 (Oct-Dec, 2013): 202.

medicine therapies and develop strategies to be used by faith community nurses which are consistent with both the practice of nursing and the faith community tenets.

## Initial Claims, Intuitions, and Assumptions

Initial claims and intuitions are embedded in the ministerial question of this thesis-project. Due to the nature of this project, the claims and intuitions for this thesis-project articulated below concern the dual disciplines of nursing and theology, and more specifically ministerial ethics.

Based on discussions with faith community nurse colleagues, it is my understanding that many denominations do not provide official directives with respect to complementary therapies. This will be formally verified through the data collection of this thesis-project.

I assert that there is difficulty with language regarding complementary verses alternative medicine therapies. Other terms such as *new age practices* may cloud the construct of complementary medicine. As a result of the ambiguity of language, fallacies may develop as to the use of a particular therapy within a specific context.

Although Western medicine practices are evidenced-based, it must be recognized that practice develops through time, and practice should be open to continued development. Most interventions used in medical practice were at one time experimental and later accepted as practice. Therapeutic treatments have planned outcomes, but are often coupled with adverse responses, as well. It must also be recognized that because a mechanism of relief may not be fully understood, it does not negate the fact that relief is perceived by an individual.

It is necessary to recognize that placebo and nocebo effects may be experienced by individuals. The placebo effect refers to the way in which a patient's beliefs or professional's bedside manner influences recovery.[22] Studies have shown that patients have improved, not because of the purported treatment, but because of the complex dynamics of the placebo effect.[23] This effect has been observed with use of medications, drugs, herbs, medical procedures and diagnostic tests.

The "nocebo effect" refers to the experience of a negative reaction to a placebo.[24] For example, a review of research studies have found that almost 25% of those given a placebo spontaneously report side effects. In fact, in some studies, individuals receiving the placebos had more adverse effects that those taking the actual medications.

The placebo and nocebo effects must both be considered when considering treatment suggestions. Both responses point to the importance of trust between patient and practitioners as well as the power of verbal suggestion.[25] Ineffective remedies may in fact produce effects, and these may be positive or negative.

I assert that faith community nurses are responsible to the ethical precepts of a professional. Faith community nursing can be viewed as a helping profession as it reflects the following characteristics: 1) the nature of the human needs it addresses, 2) the vulnerable state of those it serves, 3) the expectations of trust it generates, and 4) the social contract that it implies.[26] Faith community nurses perform a unique and essential social service, and have specialized training in the discipline of faith community nursing.

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[22] O'Mathúna and Larimore, 38.
[23] Ibid.
[24] Ibid., 40.
[25] Ibid.
[26] Trull and Carter, 30.

Faith community nurses provide a service to parishioners and have fiduciary obligations. Additionally, the faith community nurse must act within the scope and standards of the practice of faith community nursing, follow the practice act of the state in which the faith community nurse practices, and must adhere to the American Nurses Association *Code of Ethics*.

The assumption is made the good of the individual congregant in a particular situation is an important consideration, but perhaps not exclusive consideration, for the interaction between the congregant and the faith community nurse. The good of the individual also influences the decision to accept or reject a particular complementary therapy. Therefore, it is necessary for the faith community nurse to provide an appropriate response, which is ethical and authentic to the faith tradition and practice of nursing. It is neither the role of the faith community nurse to interfere with the physician-patient relationship, nor to opine against the medical advice of the primary care provider. The ultimate intent of the faith community nurse is consultative rather than prescriptive.

## Contributions to Ministry

This thesis project will contribute to my practice as it is intended to identify the current methods used by faith community nurses to determine appropriate responses to an inquiry on complementary medicine approaches, which is individually determined and consistent with professional nursing practice and the tenets of faith. After reflection on current faith community nursing practice, in concert with the resources of Scripture and Christian tradition and evidenced-based practice, an assessment of how practice may be

improved will be provided, with strategies based on the needs of the faith community nurses to determining an accurate response to complementary medicine inquiries.

This thesis-project supports the faith community nurse standard that faith community nurses are to demonstrate a commitment to lifelong learning through self-reflection and inquiry to address learning and professional growth needs.[27] Additionally, the practical theological process challenges current practices with the goal to move practice closer to faithfulness to God and God's mission in the world.[28] While this is a very limited study, it is expected that the insights gained from this process may be applicable to other ministerial situations.

Though this project will be of benefit to my particular ministerial practice, I also believe this project has the potential to contribute to the discipline of other Christian faith community nurses who face the similar decisions. Faith community nursing is a relatively new nursing specialty, recognized formally by the American Nurses Association in 1998, and the specialty continues to develop. The numbers of practicing faith community nurses are low as compared to other nursing specialties; therefore, it is important to share strategies within the field. As previously stated, while some denominations provide directives that may be used as guidelines, it is not possible for all situations to be addressed in directives. Most faith community nurses are solo practitioners, and must make ethical decisions regarding health care recommendations without guidance from other professionals.

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[27] *Faith Community Nursing: Scope and Standards*, 37.

[28] John Swinton and Harriet Mowat, *Practical Theology and Qualitative Research* (London: SCM Press, 2006), 256-257.

This thesis project offers an opportunity for collaboration among faith community nurses, and thereby offers several benefits. First collaboration satisfies one of the professional performance standards for faith community nurses.[29] Collaboration also offers an opportunity to advance the practice of faith community nursing. Finally, collaboration is a means to demonstrate fiscal responsibility as it models the biblically rooted theme of stewardship. Through this thesis-project, the examination of the current praxis and the potential for praxis recommendations to enhance the current praxis may prove useful to other faith community nurses.

## Scope and Limitations

### Scope

This thesis-project will review the current praxis of faith community nurses which serve mainline Christian denominations. The praxis will be examined and critiqued from the perspectives of evidence-based nursing practice, theological principles, Roman Catholic ethics. The aforementioned perspectives will be used to test complementary medicine therapies for recommendation or rejection.

### Limitations

This analysis will be limited by the number of available faith community nurses. As noted by Maureen Daniels, Faith Community Nurse Specialist at the International

[29] *Faith Community Nursing: Scope and Standards*, 45.

Parish Resource Center,[30] there is currently no way to determine where faith community nurses practice. Therefore, known faith community nurses will be asked to participate in the data collection for this project.

Faith community nurses from mainline Christian faith communities will be sampled. Although all denominations may not have a hierarchal structure, the mainline Christian communities have common faith tenets within the denomination. The theological reflection will include the shared resources of Christian Scripture and Tradition, which is not presumed to apply to non-Christian faith traditions.

This thesis-project will also be limited to the exploration of the construct of complementary medicine therapies, and will not include alternative medicine therapies. The conclusions of this thesis-project may be applicable to alternative medicine therapies. However, another set of considerations may be required for alternative medicine therapy consideration due to the fact that alternative therapy implies that the therapy is used in lieu of conventional therapy, as compared to complementary therapy that is used to supplement conventional therapy.

Additionally, the conclusions of this thesis-project will be limited to a specific list of complementary therapies. The list will not be inclusive of all complementary modalities.

[30] Maureen Daniels, Faith Community Nurse Specialist at the International Parish Nurse Resource Center projected 15,000 based on the number of faith community nurses that have been trained in the specialty practice. However, she added that there is currently no way to accurately count those that are practicing this specialty.

## Summary

This thesis-project is set within the dynamic practice of faith community nursing. As the landscape of medical practice shifts, so too must the faith community nurse who is charged with assisting parishioners engage in their health and well-being. As the faith community membership becomes exposed to the arena of complementary medicine therapies, the faith community nurse may not maintain a stagnant knowledge base. Spanning the disciplines of nursing and theology, the faith community nurses needs to collect and evaluate data to guide an ethical response to a parishioner query regarding a complementary medicine modality.

Situated within the discipline of practical theology, Chapter 2 will describe the process currently used by 20 faith community nurses to determine support or non-support for the use of a complementary medicine modality. Chapter 3 will suggest theoretical basis for the decision-making process used by the nurses interviewed. Chapter 4 will then examine nursing, theological, pastoral, and ethical considerations which should undergird the community nurse's evaluation process. Finally, Chapter 5 will suggest a praxis for use by faith community nurses while attempting to provide and evidence-based ethical response to the question of complementary medicine therapy use.

# Chapter 2

## What is Currently Being Done: The Current Practice

This thesis project is situated within the discipline of practical theology. The first core task of practical theology is to determine what is going on in a particular situation, the *descriptive-empirical task*.[1] Throughout this task, information is gathered with respect to the patterns and dynamics of a particular state of affairs to facilitate an understanding of the situation. Grounded in the spirituality of presence, this step often takes place in an informal manner.[2] For the purposes of this thesis-project semi-structured interviews were used to elicit the information used to describe current faith community nursing practice with respect to determining whether the use of a complementary medicine therapy by a particular congregant would be supported by the faith community nurse or not.

This chapter will provide a discussion of germane constructs of this thesis-project to provide a foundation for the reader. Faith community nursing practice, the relationship of body, mind, spirit, and health, and an overview of complementary medicine will be explored. To facilitate the reader's understanding of the specific complementary medicine therapies addressed in this thesis-project, a description will be presented, as the theoretical mechanism of the therapy may affect the faith community nurse's decision of support or not.

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[1] Richard R. Osmer, *Practical Theology: An Introduction* (Grand Rapids, MI: William B. Eerdmans Publishing Company, 2008), 4.

[2] Ibid., 34.

Following the description of the factors which intermesh within the scope of this project, results of the data collection will be provided. This section will provide an overview of the demographic data in terms of respondents interviewed, as well as information regarding the decision making process elicited from the interview process.

## Constructs

For an accurate description of a practice, it is important that terminology is consistent and understood by those providing information, as well as those analyzing and synthesizing the data received.[3] Therefore, the following definitions and descriptions are offered to mitigate misconceptions that may result from linguistic inconsistencies.

### Faith Community Nursing and Scope of Practice

*Faith Community Nursing*[4] describes a specialty practice of nursing that focuses on the intentional care of the spirit as well as on the promotion of wholistic health and prevention or minimization of illness within the context of a faith community.[5] The American Nurses Association and Health Ministries Association conceptualize wholistic

[3] Camille Eckerd Lambo, "Complementary and Alternative Therapy Use in Breast Cancer: Notable Findings," *Journal of Christian Nursing* 30, no. 4 (October-December 2013): 224. This study found that the women participants had defined complementary medicine broadly, including therapies that differed from prevailing definitions of CAM found in literature.

[4] *Faith Community Nursing: Scope and Standards of Practice,* 2nd ed. (Silver Spring, MD: American Nurses Association, 2012), 1. When faith community nursing was established in the 1980's the name for the specialty practice was Parish Nursing. In 1998, the first *Scope and Standards of Parish Nursing Practice* was published by the American Nurses Association. However, as the practice has evolved, the title was changed to Faith Community Nursing with the publication of *Faith Community Nursing: Scope and Standards of Practice* in 2005.

[5] Ibid., 5.

health as "a whole or completely integrated approach to health and healthcare that integrates the physical and spiritual aspects of the whole person."[6]

The core of the faith community nursing healthcare delivery model is the relationship between the faith community nurse and client. The client may be an individual, family, group, or community. As the client seeks wholistic healthcare and the goal of optimal wholistic health functioning, the integration of faith along with the attributes of health promotion, disease management, coordination, empowering, and accessing healthcare occurs with intentionality in a faith community.[7]

The faith community nurse possesses expertise in both professional nursing and spiritual care. The goals of faith community nursing include the protection, promotion, and optimization of health and abilities; the prevention of illness and injury; and the alleviation of suffering in the context of the values, beliefs, and practices of a faith community. To meet these goals, faith community nurses use the nursing process to address the spiritual, physical, mental, and social health of parishioners. The faith community nurse then applies the interventions of education, counseling, prayer, presence, active listening, advocacy, referral, and available resources.[8]

Reverend Dr. Granger Westberg may be considered the father of modern faith community nursing. As a young Lutheran Pastor, Westberg recognized that the body could not be treated separately from the mind and spirit. Westberg had the vision clergy,

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[6] Deborah J. Ziebarth and Katora P. Campbell, "A Transitional Care Model: Using Faith Community Nurses," *Journal of Christian Nursing* 33, no. 2 (April-June 2016): 114. See chapter 1 for additional discussion regarding the distinction between "wholistic" and "holistic."

[7] Ibid.

[8] *Faith Community Nursing: Scope and Standards of Practice,* 2nd ed., 5-6. The person, client, family, group, community, or population is the focus of attention of the faith community nurse as healthcare consumer; however, for the purposes of this paper, parishioner or congregant will be used.

nurses, and physicians could work together to care for the whole person. Through his experiences in hospital and clinical settings, he (Westberg) noticed and respected the innate ability nurses had to care for the whole person: the body, mind, and spirit. He also recognized the nurse's pivotal role in the care of each patient.[9]

Westberg participated in a group who worked in the late 1960's with a grant from the W.K. Kellogg Foundation and Department of Preventive Medicine and Community Health at the University Of Illinois College Of Medicine to establish "Wholistic" Health Centers. The centers were family doctors' offices in churches. The goal of this project was to determine if whole person healthcare could be provided in a church setting through a team of spiritually oriented family doctors, nurses, and clergy. Although critics of the project doubted scientific medicine and religion could collaborate with each other, evaluation demonstrated that the professionals working together was measurably more "wholistic" than the average doctor's office. Nurses were found to be the "glue" that bound the professions. Furthermore, it was noted the nurses in the clinics were proficient in two languages; they could speak the language of science and the language of religion.[10] In 1985, in cooperation with Lutheran General Hospital in Park Ridge, Illinois, a pilot project was established with six churches, four protestant and two Roman Catholic, and the current practice of faith community nursing was born.[11]

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[9] Phyllis Ann Solari-Twadell and Mary Ann McDermott, eds. *Parish Nursing: Development, Education and Administration* (St. Louis, MO: Elsevier Mosby, 2006), xiv.

[10] Jane Westberg, "A Personal Historical Perspective of Whole Person Health and the Congregation," in *Parish Nursing: Development, Education and Administration*, eds. Phyllis Ann Solari-Twadell and Mary Ann McDermott (St. Louis, MO: Elsevier Mosby, 2006), 5.

[11] Ibid., 6.

Although faith community nursing is a newly recognized nursing specialty, nursing is deeply rooted in faith and health as well as ancient and recent traditions of many religions. Historically, faith traditions established rules for public health. Visiting the sick and caring for infants and the elderly has historically been a religious duty.

The genesis of faith community nursing can be traced to a community of Roman Catholic sisters. After the death of her husband in 1624, Louise de Marillac sought out Vincent de Paul to serve as her spiritual director. Louise had experienced a revelation from God that she would serve God through assisting her neighbor, and she wished to develop a way in which to fulfill this revelation. Concurrently in 1617, Vincent de Paul established Confreries de la Charite (*charities*) throughout rural France which consisted of wealthy women called "Ladies of Charity" who visited the sick in their homes and provided nursing care and spiritual comfort. In 1629, Louise de Marillac became the leader of the first *charitie* in Paris.[12]

The intentional care of the spirit, differentiates faith community nursing from the generalized practice of nursing, although spiritual care is part of all nursing practice. Faith community nursing recognizes that through the care of the spirit, healing may occur even if cure (physical restoration) does not occur. While there may be a time in one's life when cure is not likely, it does not negate the possibility of healing; the state of mind whereby an individual is at one with themselves, others, the environment and God.[13] Healing restores people to peace, wholeness, and harmony, and through this restoration

[12] Solari-Twadell and Egenes, 11.

[13] Barbara Burden, Sandy Herron-Marx, and Collette Clifford, "The Increasing Use of Reiki as a Complementary Therapy in Specialist Palliative Care," *International Journal of Palliative Nursing* 11, no. 5 (2005): 248.

people may find meaning for their lives.[14] An example of this phenomenon may be seen as a person suffering the ravages of cancer, achieves a peace, in spite of the fact that the cancer is not cured. Response to situations that threaten wholistic health requires the faith community nurse integrate spiritual care and nursing care and utilize available resources.[15]

A nursing specialty recognized by the American Nurses Association in 1998, faith community nursing has a unique scope of knowledge and standards of practice. *Faith Community Nursing: Scope and Standards of Practice, Second Edition*, articulates the practice of faith community nursing. It is shaped by the foundational documents *Nursing: Scope and Standards of Practice*, the *Code of Ethics for Nurses with Interpretive Statements*,[16] and *Nursing's Social Policy Statement: The Essence of the Profession* which binds all registered nurses.

Each role of the faith community nurse requires ethical decision making,[17] and the charge of Professional Performance Standard 7 of *Faith Community Nursing: Scope and Standards of Practice, Second Edition*[18] reflects this mandate. It reads, "The faith community nurse practices ethically."[19] Ethics, a systematic study of morality, is concerned with the standards of moral conduct and moral judgments. While faith community nurses face many of the same ethical issues as nurses in other health care

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[14] Mary Birmingham, *Breaking Open of the Word, 5th Sunday in Ordinary Time B*, (San Jose, CA: TEAMRCIA, 2011), 9.

[15] *Faith Community Nursing: Scope and Standards of Practice, 2nd ed.*, 8-9.

[16] See Appendix C for a listing of the American Nurses Association Code of Ethics.

[17] Janet S. Hickman, *Fast Facts for the Faith Community Nurse* (New York: Springer Publishing Company, 2011), 66.

[18] See Appendix B for the specific competences of this standard.

[19] *Faith Community Nursing: Scope and Standards of Practice, 2nd ed.*, 35.

settings, faith community nursing is a nursing specialty which involves both professional nursing practice and ministerial practice, and therefore bound by professional nursing concerns and ministerial concerns.

From the professional nursing practice standpoint, the *ANA Code for Nurses with Interpretive Statements* (2015) provides the faith community nurse with the ethical standards for nursing practice, research, and education. Adherence to the principles of bioethics is also a requirement of the nursing profession. Bioethical principles include respect for autonomy, nonmaleficence, benificience, distributive justice, confidentiality, veracity, and fidelity.[20]

The faith community nurse must also adhere to the professional expectations of ministerial practice which is situated within the theological foundation of a faith community. This framework includes Scripture, creeds, prayers, and other faith community tenets and teachings.

## Body, Mind, Spirit, and Health

The bio-psycho-social model of healthcare has been accepted in mainstream healthcare. This model suggests that all disease has a psychosomatic component and biologic, psychologic and social factors are always involved in the patient's symptoms or

[20] Hickman, 64-65.

disease. Various states of consciousness and spirituality are secondary factors in this healthcare model.[21]

This model also developed in the practice of nursing. Although spiritual care has historically been part of the practice of nursing, beginning in the latter half of the 20th century, nursing shifted from the vocational focus of spiritual care to science and the profession of nursing. A dearth of professional literature offering perspectives and guidance with the spiritual aspects of nursing care supported the decreased focus on the spiritual care of patients.[22]

Faith Community Nursing embraces the understanding that individuals are bio-psycho-social-spiritual beings, and the state of the constellation of these components is a determining factor of one's health. Supporting all facets, wholistic care, can help to bring about a healthy balance in one's life.

Research is proposing that one's view of life and the satisfaction with one's life influences one's health. When one is content with what one is doing, and one sees purpose or meaning in life, it is more likely that a healthy life is experienced. Factors which may affect the state of one's health include relationships, activities, and spiritual ties.[23]

Having positive relationships can support a healthy state. For instance, while stress can reduce one's immune system having others with whom one can speak helps to

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[21] "Definitions and Concepts," in *Holistic Health Promotion and Complementary Therapies: A Resource for Integrated Practice,* eds. Simon Weavers and Loretta Haught (Gaithersburg, MD: Aspen Publishers, 1999):1-1:1.

[22] Lynne Sanders, Sharon Kopis, Carolyn Moen, Angela Pobanz, and Fred Volk, "Perceptions of Spirituality and Spiritual Care in Religious Nurses," *Journal of Christian Nursing* 33, no. 4 (October-December 2016): 214.

[23] Brent Bauer, ed., *Mayo Clinic Book of Alternative Medicine, 2nd ed*. (New York: Time, Inc., 2010), 36.

mitigate stress, anxiety and depression. A support system can also help one cope with a major life event leading to a more positive outcome.[24]

Meaning or purpose in one's life may be derived through activity which can be a factor in one's health. The activity need not be dramatic such as scaling a mountain. Even small experiences, such as dinner with a friend can provide pleasure satisfaction.[25]

"To be human means to be spiritual,"[26] and one's spiritual life may also affect one's health. Although related, the terms of *spirituality* and *religion* are not synonymous. "Religion may be defined as a system of beliefs and practices observed by a community, supported by rituals that acknowledge, worship, communicate with, or approach the Sacred, the Divine, God (in Western cultures), or Ultimate Truth, Reality, or nirvana (in Eastern cultures)."[27] Scriptures, teachings, and a moral code are common features of a religion. Religious practices may be public or private. Religious depth may be reflected by participation in religious practices, but this is not necessarily the case.

Although more individualized and self-determined, spiritualty is related to the way in which the individual is religious. To be a spiritual being means knowing and living in the knowledge that there is more to life than just what can be seen. More specifically for the Christian, spirituality includes the notion that God is present.[28] Spiritual beliefs and practices help an individual connect to something greater, and the

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[24] Ibid.

[25] Dan Buettner, *The Blue Zones,* 2nd ed. (Washington DC: National Geographic, 2012) studied three populations with concentrations of some of the world's longest-lived people, also referred to as "Blue Zones." The studies revealed nine longevity lessons or principles which included 1) the need to move, 2) decreasing caloric intake, 3) eating a plant based diet, 4) drinking red wine in moderation, 5) having a sense of purpose, 6) decreasing stress, 7) having a sense of belonging/participating in a spiritual community, 8) making family a priority, and 9) being surrounded by those who share the same Blue Zone values.

[26] Carolyn Gratton. *The Art of Spiritual Guidance* (New York: Crossroad, 1992), 2.

[27] Harold G. Koenig, *Medicine Religion and Health* (West Conshohocken, PA: Templeton Press, 2008), 11.

[28] Richard P. McBrien. *Catholicism* (New York: HarperCollins Publishers, 1994), 1019.

belief that the higher power helps coping with life situations.[29] While often associated with religion, spirituality is not always defined in terms of religion, spirituality may be secular.[30] For the purposes of this thesis-project the definition for Christian spirituality will be "the particular way in which the breath of God enlivens us."[31]

Although the role of faith and Christianity as a form of Complementary and Alternative Medicine practice has not been fully studied with respect to potential benefits of patients, religion and spiritual practices are known to impact health.[32] The example, depression often occurs in those with chronic medical illness; in fact major depression is seen in those with chronic medical illness at a rate three times higher than the general population. Religious coping has been shown to be widely prevalent among those with medical illness and has been associated with less depression and faster recovery from depression. Psychotherapy that integrates religious beliefs of medically ill clients may be particularly effective in relieving depression.[33] Patients have reported using faith and support from God to deal with the emotional and physical sequelae of disease. Additionally, God was imaged as partner, social support, and confidant through a difficult period.[34]

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[29] Bauer, 36.

[30] Koenig, 14.

[31] Sallie Latkovich, SSJ. "Christian Spirituality," Lecture for the Blessed Edmund Rice School of Pastoral Ministry, January 22, 2001.

[32] Camille Eckerd Lambo, "Complementary and Alternative Therapy Use in Breast Cancer: Notable Findings," *Journal of Christian Nursing* 30, no. 4 (October-December 2013): 219.

[33] Harold Koenig, Michelle J. Pearce, Bruce Nelson, Sally F. Shaw, Clive J. Robins, Noha Daher, Harvey Jay Cohen, Lee S. Berk, Denise L. Bellinger, Kenneth I Pargament, David H. Rosmarin, Sasan Vasegh, Jean Kristeller, Nalini Juthani, Douglas Nies, and Michael B. King, "Religious vs. Conventional Cognitive Behavioral Therapy for Major Depression in Persons With Chronic Medical Illness: A Pilot Randomized Trial," *The Journal of Nervous and Mental Disease* 203, no. 4 (April 2015): 243.

[34] Lambo, 223.

## Complementary and Alternative Medicine

Although the boundaries are not always clear, medical interventions are often divided into two categories, conventional/western therapies and alternative and complementary therapies. Conventional therapies are commonly associated with medical physicians, hospitals, and the modern Western healthcare system. The focus of conventional intervention is "the use of pharmaceuticals, surgery, technology, and physical devices to prevent, diagnose, treat, and cure disease."[35] These therapies are generally practiced by Western trained physicians, or taught in most medical schools. Alternative and complementary medicine therapies may be placed in this category when high quality research shows evidence of benefit and safety, and the therapy is recommended by conventional health care practitioners.[36]

In the past few decades, the use of complementary and alternative treatments has increased. Complementary therapies, many with roots in eastern medicine, are based on the premise of addressing the body, mind, and spirit, and often aim to control symptoms through an enhancement of quality of life.[37] In 2002, approximately 36% of the adult population in the United States had used some form of complementary of alternative medicine practices, and this increased to 38% in 2007.[38] The 2007 survey also showed that 12% of children were using some form of complementary or alternative medical approach.[39] Complementary and alternative medicine therapies are used to treat conditions such as back pain, joint stiffness, arthritis, anxiety, insomnia, and to prevent

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[35] Dónal O'Mathúna and Walt Larimore, *Alternative Medicine: The Christian Handbook* (Grand Rapids, MI: Zondervan, 2007), 29.

[36] Ibid.

[37] Burden, Herron-Marx, and Clifford, 248.

[38] O'Mathúna and Larimore, 14-15.

[39] "Exploring the Science of Complementary and Alternative Medicine: NCCAM Third Strategic Plan 2011-2015." (Washington DC: National Institute of Health, 2011), 2.

head or chest colds, manage cholesterol, and control headaches.[40] These therapies account for about 10% of out of pocket healthcare expenses,[41] an estimated $33.9 billion was spent in 2007.[42]

Although the terms *alternative medicine therapy* and *complementary medicine therapy* are sometimes used interchangeably, for this thesis project, the terms will have specific meaning. Aligned with the definition used by the National Institute of Health, National Center for Complementary and Integrative Health (NCCIH),[43] alternative medicine therapies will refer to non-mainstream practices that are used in lieu of conventional medicine treatment for the purpose of treating or ameliorating disease.

According to NCCIH, alternative medicine is uncommon. Alternative medical systems are built upon alternative systems of theory and practice that have evolved over time in different cultures and apart from conventional or Western medicine[44] and are used in place of conventional medical practice. Such practices include Ayurvedic medicine also known as Ayurveda, naturopathic medicine, homeopathic medicine, and traditional Chinese medicine. For example, Ayurvedic medicine is one of the oldest known medical systems, originating in India more than 3,000 years ago, and it is still one of India's traditional health care systems.[45] The term *Ayurveda* is a combination of the Sanskrit word *ayur* meaning life and *veda* meaning science or knowledge. Ayurvedic physicians

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[40] O'Mathúna and Larimore, 14-15.

[41] Lauren Cox, "Why is Alternative Medicine Popular?" *Alternative Medicine: Opposing Viewpoints* (New York: Gale Cengage Learning, 2012), 100.

[42] "Exploring the Science of Complementary and Alternative Medicine: NCCAM Third Strategic Plan 2011-2015," 2.

[43] "Complementary, Alternative, or Integrative Health: What's In a Name?" https://nccih.nih.gov/health/integrative-health (accessed April 29, 2015).

[44] Lambo, 224.

[45] "Ayurvedic Medicine: An Introduction." https://nccih.nih.gov/health/ayurveda/introduction.htm (accessed April 29, 2015).

prescribe individual treatments using the principles of interconnectedness, the body's constitution, and life forces. Predating written records, many Ayurvedic practices were handed down orally. Although Ayurveda is supported by India's government and other institutes throughout the world within the context of the Eastern belief system, it has not been widely studied as part of conventional medicine. This medical approach uses a variety of practices and products which may contain herbs, minerals, or metals which may produce negative effects or be harmful if used improperly.[46]

Another example of the alternative medical approach grouping is homeopathy, also known as homeopathic medicine. This practice which was developed in Germany more than 200 years ago has been practiced in the United States since the 19th century. Using the principles of the law of similar and the law of infinitesimals, the goal of homeopathy is to simulate the body's ability to heal itself by giving small doses of highly diluted substances called remedies which natural substances.[47] Although homeopathic remedies are regulated by the US Food and Drug Administration (FDA), the FDA does not evaluate for safety or effectiveness. Because it is assumed that the homeopathic remedies are highly dilute it is presumed they are unlikely to cause harm, however they may contain sufficient amounts of active ingredients to cause side effects and drug interactions.[48]

In contrast to alternative medicine practices, for the purposes of this thesis-project, complementary medicine therapies will refer to interventions used with

[46] Ibid.

[47] Bauer, 144.

[48] "Homeopathy: An Introduction." https://nccih.nih.gov/health/homeopathy (accessed April 29, 2015).

conventional or traditional therapies for purpose of treating or ameliorating disease.[49] Integrative medicine is the term used for the blend of conventional medicine and non-Western approaches of complementary medicine. The focus of integrative medicine is to treat, not just the disease process, but also the mind, body, and spirt of the individual. Integrative medicine combines the best current conventional medicine with the best non-traditional practices.[50]

The healthcare system faces an aging population and expensive medical technology, which is often perceived as too technical and "cold" in spite of its promises and abilities. This confluence of factors has contributed to a new model of health care which offers potential through complementary and alternative medicine practices to meet the physical, mental, and spiritual needs of an individual. These practices may not be new, per se, the difference is the recognition that these, sometimes ancient practices, may have a value in meeting the healthcare needs of individuals.[51]

The NCCIH has concluded that complementary health approaches generally fall into two subgroups. The subgroups are natural products and mind and body practices.[52]

The first category includes products such as herbal supplements, vitamins and minerals, probiotics, and dietary supplements. In a 2012 National Health Institute survey of Americans, it was found that 17.7% had used natural products, other than vitamins and

[49] Sue Fowler and Linda Newton, "Complementary and Alternative Therapies: The Nurse's Role," *Journal of Neuroscience Nursing* 38, no. 4 (August, 2006): 261.

[50] Bauer, 9-10.

[51] Ibid., 9.

[52] "Complementary, Alternative, or Integrative Health: What's In a Name?"

minerals, in the previous year.[53] These products were also the most commonly used complementary health approach; in fact about 25% of patients who took prescription medications also took some kind of dietary supplement.[54]

However, this subgroup of complementary health approaches will not be explored in this thesis-project for several reasons. First, this is a very broad category, too broad for the scope of this project. Next, this category includes approaches which involve the ingestion of products which may not be regulated. Without regulation, formulas may vary, and quality may not be as closely controlled as with regulation. Although herbal products are often seen as harmless or benign, they can produce toxicity and adverse reactions and interactions. Different parts of plants are used and different formulations are created, so potency and toxicity can vary.[55] The ingestion of unregulated products may lead to different ethical considerations than those found with the approaches found in the mind body category. Finally, although large and rigorous studies on a few natural products have been conducted, the results showed that the products did not work.[56]

Body-mind interventions, the second category of complementary medicine approaches identified by NCCIH, include a variety of practices designed to enhance the mind's capacity to affect the body.[57] These approaches, taught by a trained practitioner or teacher, help an individual use the power of the mind to prevent or decrease disease, enhance healing, and promote well-being. It is believed that the health and vitality of the

[53] "Complementary, Alternative, or Integrative Health: What's In a Name?" Katherine Pereira, "Herbal Supplements: Widely Used, Poorly Understood," *Nursing 2016* 46, no.2 (February, 2016): 55.

[54] Pereira, 56.

[55] Ibid..

[56] "Complementary, Alternative, or Integrative Health: What's In a Name?"

[57] Ibid.

mind is important to maintain good health and live a balanced and satisfying life.[58] Simply stated, mind-body medicine positively influences the mind to improve the health of the individual.[59]

The acceptance of a connection between the mind and body is centuries old. However, with the development of Western medicine during the 17th century, the combined approach to health and wellness fell out of popularity. Western medicine advances and the development of medications and surgical interventions to cure disease led to a concentration on treating disease biologically. However, there has been emerging acceptance treating disease solely on a biological level may not be enough, and interest in holistic health and healing has increased.[60]

Mind-body practices have the goals of restoring the mind to a state of peaceful neutrality through shedding negative experiences, and to use the ready mind to achieve beneficial health effects. These results may be accomplished through various activities such as spiritual interventions such as prayer; spoken interventions such as transcendental meditation, biofeedback, or cognitive-behavioral therapy; practices involving breathing and posture such as Tai chi and Yoga; or soothing imagery such as guided imagery.[61]

One possible explanation for the action of body-mind practices suggests two processes work simultaneously within one's mind, attention and interpretation. Attention helps screen, select, and absorb sensory information from the world. This information is then interpreted based on previous experience, preferences, and a planned course of

[58] Bauer 96.
[59] Ibid., 97.
[60] Ibid.
[61] Ibid.

life.[62] Stress, sleeplessness, decreased quality of life, and predisposition to other medical conditions can occur when one's attention focuses on imperfections of either the material world, or within the contents of one's mind. Interruption in the negative thought loop, through body-mind complementary therapies can alter the course of the body's response.

One of the complementary medicine approaches to be discussed in this thesis-project is acupuncture. Acupuncture and its use can be traced in the Chinese health care system at least 2500 years,[63] the first known mention of acupuncture found in writing from 600 BC.[64] The traditional Chinese practice of acupuncture is based on the theory that the body is a delicate balance between two opposing and inseparable forces, yin which represents the cold, slow, or passive principle and yang which represents the hot, excited, or active principle. It is believed that health is achieved through the maintenance of the body in a balanced state, and disease is caused when an imbalance between the two states exists.[65]

The word acupuncture is derived from the words *acus* meaning "needle" and *pungere* meaning "prick."[66] While there are variations in the technique, the modality of acupuncture involves the stimulation of anatomical locations, named *acupoints*, through the insertion of very fine needles (0.15 to 0.30 mm in diameter) into the body at various depths.[67] The traditional Chinese practice is based on the idea that the body has an invisible life energy force known as *chi* or *Qi* which flows through invisible pathways

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[62] Ibid., 96.

[63] National Institutes of Health. "Acupuncture." *NIH Consensus Statement*, 15, no. 5 (1997): 3.

[64] Dana Bartlett, *Acupuncture*, Nursece-4less.com, June 26, 2014, 8.

[65] Brinkman, Susan. *Is Acupuncture Acceptable for Catholics?* http://www.catholicculture.org/culture/library/view.cfm?recnum=8758 (accessed August 31, 2014).

[66] Ibid.

[67] Bartlett, 10.

known as meridians. The proper flow of *chi* helps the body adjust to stresses. When this flow is disturbed, Chinese medicine practitioners believe that acupuncture can restore the proper flow of *chi*.[68]

Western scientists are not convinced of chi meridians and alternate theories have been advanced. One theory is that acupuncture may work by releasing endorphins which are naturally occurring hormones that regulate perception pain perception.[69] Another theory is that stimulating nerves in the spinal cord may release pain-suppressing neurotransmitters.[70] Another theory of the mechanism of acupuncture is based on the observation that pain in one area of the body may be reduced when another part of the body is irritated,[71] also known as a counterirritant. Others purport that the placebo effect is created through the use of acupuncture.[72]

Although the exact mechanism of acupuncture may not be understood, the practice of acupuncture has increased in popularity in the last few decades and is used by many physicians, dentists, acupuncturists, and other practitioners for relief or prevention of pain and for a variety of health conditions. The National Health Institute Survey (2002) of complementary and alternative medicine estimated that 8.2 million adults in the United Stated had used acupuncture at some time, and an estimated 2.1 million adults in the United States had used acupuncture in the previous year[73] and data from 2008 found

[68] O'Mathúna and Larimore, 129.
[69] Ibid., Brinkman, *Is Acupuncture Acceptable for Catholics?*
[70] Brinkman, *Is Acupuncture Acceptable for Catholics?*
[71] O'Mathúna and Larimore, 130.
[72] Ibid., 129-130.
[73] Brinkman, *Is Acupuncture Acceptable for Catholics?* .

that approximately 3.1 million adults in the United States had used acupuncture in the preceding year.[74]

Biofeedback is another complementary therapeutic intervention classified within the sphere of mind-body medicine. Through biofeedback, individuals can learn how to control functions of the body such as skin temperature, heart rate, and brain wave patterns, once thought to be beyond conscious control.[75]

Biofeedback can be found in a variety of clinical settings which include physical therapy clinics, medical centers, and hospitals. A typical session lasts from 30-60 minutes. A practitioner places electrical sensors on different anatomical locations which monitor the body's response to stress, such as muscle contraction. This information is then fed back through sound and visual cues. With the use of the cues, one starts to associate the body's response with certain physical sensations. The individual then learns to elicit positive physical changes, such as muscle relaxation, when physical or mentally stressed. The ultimate goal is for the individual to produce the appropriate response outside the clinical setting.[76]

For instance, deep breathing has been demonstrated to reduce blood pressure. Through the use of a heart rate variability monitor, a sensor placed at the fingertip or earlobe, the breathing pattern and the time between heart beats is displayed as a wave formation. When stressed, a jagged and spiky wave form is generally displayed.

[74] Barltett, 7.
[75] O'Mathúna and Larimore, 140.
[76] Bauer, 98.

Through controlling breathing, the heart rate variability is affected, and the wave form changes,[77] providing a visual cue of the change.

Another subset of body-mind practices is hand-mediated energetic healing practices (HMEH), which includes the two most prominent touch practices of healing touch and therapeutic touch. Although the non-invasive HMEH practices have been included in nursing school curriculum and are considered nursing techniques, these techniques are not solely practiced within the domain of nursing. HMEH complementary therapy practices are also practiced by non-nurses and non-health care providers.[78] The word "touch" may be misleading, as research has demonstrated one need not physically touch the recipient to achieve the desired effects.[79]

The effects of HMEH are attributed to energy for the following reasons. First, energy is the closest image to what practitioners and recipients describe feeling during the session. Second, the results attributed to HMEH cannot be the result of physiologic responses to physical touch.[80] The foundation of energetic healing and HMEH is the understanding that the human body has an electromagnetic field (aura). This field can be experienced when a person outside the visual field quietly enters a room on the presence if felt by another. The body also has an electric current that flows along parallel pathways (meridians) and information analyzing structures (chakras). One's body uses the energy and one's consciousness gives meaning to the information.[81]

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[77] Bauer, 99
[78] Weavers and Haught, 2-8:1-2.
[79] Ibid., 2-8:1.
[80] Ibid.
[81] Ibid., 2-8:2,7.

HMEH is based on the idea that the hands of practitioners transmit "energy forces" that improve the energy flow which runs through the body of the recipient. Practitioners assert that through their hand movement they are able to locate and remove energy force disturbances.[82]

To assess the energy condition of the recipient, the practitioner begins with his/her hands a few inches above the body. The practitioner then touches various energy points on the body in a manner designed to move energy from the practitioner to the recipient. This technique is thought to strengthen and reorient the energy flow within the recipient.[83]

This complementary therapy practice (HMEH) draws on the ancient healing practices of many cultures which include the Indian culture, Asian culture, and the American Indian culture. Touch therapy may be combined with religious beliefs and practices, however therapeutic touch differs from "laying on of the hands," in that it does not require professed faith or belief by the practitioner or patient.[84] The goal therapeutic touch is to restore harmony and balance in the energy system to promote self-healing.[85] Healing touch relies on the practitioner's ability to interpret the receiver's energy flow and select appropriate intervention and protocols.[86]

HMEH has been used by nurses in a variety of practice arenas such as hospitals, nursing homes, home health care, and hospice care. It has been used to help reduce

[82] Bauer, 117.
[83] Ibid., 124.
[84] Weavers and Haught, 2-8:4.
[85] Ibid., 2-8:7.
[86] Ibid., 2-8:1.

edema, temperatures, hives, pain, anxiety, premenstrual syndrome, fatigue, depression, diarrhea, and headache as well as during chemotherapy and following radiation therapy.[87]

When considered, prayer is a high frequency complementary therapy practice; however, some exclude prayer in consideration of complementary practices. A central expression of Judeo-Christian faith traditions, prayer is broadly understood to be a vehicle for communication with God.[88] One way in which a person may express his/her spirituality, research shows that prayer is the most frequently used complementary therapy.[89]

Prayer may be defined as a response to God's initiation of communication with us, a response through which one is open to the presence of God.[90] Through prayer, the Christian has an opportunity to experience a communion with God through Christ in the Church,[91] consciously acknowledging one's actual situation before God.[92] Prayer may be meditative or quiet prayer, colloquial or spontaneous prayer, petitionary for specific

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[87] Ibid., 2-8:2.

[88] Helen Wordsworth, "Prayer," in *Foundations of Faith Community Nursing* (Memphis, TN: International Parish Nurse Resource Center, 2014), Unit 1, 2. Although practices may vary reflecting cultural differences, most religions are characterized by the practice of praying.

[89] YeounSoo Kim-Godwin, "Prayer in Clinical Practice: What Does Evidence Support?" *Journal of Christian Nursing* 30, no. 4 (October-December 2013): 209. The Centers for Disease Control and Prevention (CDC) and the National Center for Complementary and Alternative Medicine (NCCAM) found prayer to be the most commonly used CAM among 31,044 adults in 2002, 43% reported they had used prayer specifically for their own health during the prior 12 months. According to a USA Today/Gallup poll in May of 2010, 92% of 1000 adults believed in God, and 83% stated that God answers their prayers. Lambo, 220. Lambo reported women who reported they did not take part in organized religion, but they prayed. Koenig, 55. Koenig reported that 44% of 382 randomly selected persons in California identified prayer as the most common unconventional remedy mentioned for musculoskeletal pain.

[90] McBrien, 348. Prayer is defined by the *Catechism of the Catholic Church* as "the elevation of the mind and heart to God in praise of his glory; a petition made to God for some desired good, or in thanksgiving for a good received, or in intercession for others before God." Wordsworth, Unit 1, 4, attributed this ancient definition of prayer to Augustine.

[91] *Catechism of the Catholic Church*, 2nd ed, (Citta del Vaticano: Libreria Editrice Vaticana, 1997), 894.

[92] McBrien, 356.

requests, and ritual in nature,[93] and themes of prayer concern praise and thanksgiving, contrition, and petition.

Prayer of petition may be used with respect to one's health situations or for the needs of others. Many faith communities include prayers for their sick members, and have groups whose mission is to pray for those who are sick.

Prayer may be private/personal or intercessory. Intercessory prayer includes communication with God on behalf of others. This form offers prayers for the people and from the people on their behalf,[94] trusting God will act toward the good of the other person. Engaging in intercessory prayer requires two movements. First, one must enter the situation of the individual through personal contact, listening, and empathy. The prayer then moves toward God, on behalf of the other.[95]

Proximal intercessory prayer refers to direct-contact prayer which often involves touch by one or more persons on behalf of another. Distance intercessory prayer refers to intercessory prayer in which there is no contact between the individual praying and the person receiving the payer. Distance intercessory prayer is done by an external agent and may be done with or without the knowledge and approval of the recipient.[96]

Christians are to participate in prayer daily, and Christian traditions encourage private and corporate prayer. Prayer may be within the context of liturgy, for instance

[93] Mary T. Sweat, "Why is Prayer Important?" *Journal of Christian Nursing* 30, no 3 (July-September 2013): 182.

[94] Osmer, 35.

[95] Ibid.

[96] Kim-Godwin, 210.

within the Episcopal, Lutheran, and Catholic faith traditions. Informal prayer is found in non-liturgical evangelical and gospel faith communities.[97]

Prayer is thought to be an effective adjunct to healthcare offering the potential to promote mental health, providing peace and hope for patients, and prayer may help to relieve stressful situations,[98] and has been used as a coping strategy for musculoskeletal pain relief.[99] As psychological stress and depression can affect one's physical health, then prayer may be beneficial as individuals report it aids with coping and reduction of stress levels.[100]

Reflexology is based on the theory that specific areas on the soles of one's feet corresponds to other parts of the body, such as the head, neck, and internal organs. While this might look like simple foot massage to the untrained, reflexologists claim to use foot charts to guide the massage and manual pressure to specific areas of the feet in an effort to influence a problem elsewhere in the body.[101] Reflexology is based on the theory that there are ten vertical zones running from the feet to the head, and down each arm. Energy is thought to flow through each zone which must be balanced in order for the organs within each zone to be healthy. Imbalances lead to an accumulation of waste material, and reflexologists posit that the application of pressure at reflex points break up the accumulations. Although some might say that this therapy is similar to the energy

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[97] Wordsworth, Unit 1, 2-3.

[98] Cheryl Patton, "Surprised by Prayer," *Journal of Christian Nursing* 33, no. 4 ((October-December 2016): 252.

[99] Koenig, 55-56.

[100] Ibid., 56, 143. The use of prayer as a coping strategy is not geographically limited. Koenig reports studies demonstrating the use of prayer as a coping mechanism conducted in North Carolina, California, India, Switzerland, Egypt, Jordan, and Australia. Harold G. Koenig, Dana E King, and Verna Benner Carson. *Handbook of Religion and Health*, 2nd ed. (New York: Oxford University Press, 2012). 86.

[101] Bauer, 136.

therapies of traditional Chinese medicine, some supporters stating that it is based on a completely different type of energy.[102] Other practitioners make no distinction in the concept of life energy used in therapeutic touch, acupuncture, and other energy therapies.

In 1915 William Fitzgerald, MD, an otolaryngologist, developed the forerunner of reflexology, based on the idea of "zone therapy." Similar therapies were practiced 4000 years ago in Egypt, India, and China.[103] Today, European countries report reflexology to be the most popular complementary therapy, and the United Kingdom reports it to be the most popular complementary therapy practiced by nurses. Reflexology may also be combined with other hand-on therapies offered by chiropractors and physical therapists.[104]

The practice of Reiki is used for relaxation, stress reduction, and to promote healing.[105] Rieki is an example of a complementary modality considered in this project which uses a theory of energy medicine. Energy medicine is largely understood to involve understanding how the body creates and responds to electric, magnetic, and electromagnet fields including light and sound, heat, pressure, chemical and elastic energy, and gravity. The focus of energy medicine is the mechanism of production of these different kinds of energy by the body and the application to body for beneficial effects.[106]

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[102] O'Mathúna and Larimore, 250-251.

[103] Ibid., 250.

[104] Ibid.

[105] Barbara Byrne Notte, Carol Fazzini, and Ruth A. Mooney, "Reiki's effect on patients with total knee arthroplasty: A Pilot Study," *Nursing 2016* 46, no 2 (February 2016): 17.

[106] William Lee Rand, "Science and the Human Energy Field," *Reiki News Magazine* 1, no. 3 (Winter 2002): 1.

Defined as a complementary biofield energy therapy that involves the use of hands to help strengthen the body's ability to heal, [107] Reiki was originally developed in Japan by Mikao Usui in Japan. It was introduced to America in 1935 by Madame Hawayo Takata. The term Reiki means universally guided or spiritual energy. Specifically, the definition of *rei* is intelligence that guides the creation and functioning of the universe, and *ki* which means life force that flows through every living thing.[108] This universal life energy is thought to be a visible and palpable life force energy that infuses and permeates all living forms, a vibrational pulsating universal energy.

The theory of Reiki expresses that illness is caused by a disruption in one's "life energy."[109] Health and healing involve the integration of the human and environmental energy fields and a mind-body connection.[110] Though the precise mechanism of energy healing is not understood, the role of the practitioner is to release the blockage in the body's natural flow of energy through the transfer of energy from the practitioner to the patient.[111] This is accomplished by the practitioner placing his/her hands in designated positions on the client's body, depending on the problem to be addressed.[112]

The ability to heal oneself and others is passed on through "initiation" or "attunement." Four key determinants of Reiki are 1) the ability to perform comes through receiving an attunement, 2) all Reiki techniques are part of a lineage passed on

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[107] Anne Vitale, "An Integrative Review of Reiki Touch Therapy Research," *Holistic Nursing Practice* 21, no. 4 (July/August 2007): 167.

[108] Burden, Herron-Marx, and Clifford, 249.

[109] United States Conference of Catholic Bishops, Committee on Doctrine. Guidelines *for Evaluating Reiki as an Alternative Therapy* (Washington DC: United States Conference of Catholic Bishops, March 25, 2009), #4.

[110] Vitale, 167.

[111] Burden, Herron-Marx, and Clifford, 249.

[112] United States Conference of Catholic Bishops, Committee on Doctrine, #4.

from master teacher to student who are prepared to receive and channel universal life energy to themselves and others, 3) Reiki energy is not guided by the mind but by the higher power, and 4) it can do no harm.

Reiki treatment is activated by compassionate intent of the practitioner to practice the highest good. The essence of caring focus helps to shape the practitioner-patient experience which can transcend just the physical or biological level. Practitioners place their hands lightly on or just above the person, with the aim of assisting the healing response of the recipient.[113] Treatment is considered holistic, non-invasive, and can occur in any care setting. Reiki is not gender, age, nor culture specific and Reiki is neither symptom nor pathology specific.[114]

Tai chi or Tai chi chuan which literally means "supreme ultimate power,"[115] originated in ancient China approximately 2000 years ago as a martial art and form of self-defense. Described as "moving meditation,"[116] Tai chi consists of a defined series of breathing exercises, postures, and movements which occur in a slow and gentle manner. Each movement flows into the next movement without pause, combining into one long exercise.

The precise historical development of tai chi is unknown; however, a popular legend attributes its origins to Chang San-Feng, a Taoist monk, who developed a set of 13 exercises which imitate the movements of animals. San-Feng emphasized the concept

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[113] "Reiki: What you Need to Know." https://nccih.nih.gov/health/reiki/introduction.htm (accessed April 29, 2015).

[114] Burden, Herron-Marx, and Clifford, 252.

[115] O'Mathúna and Larimore, 258.

[116] "Tai Chi: An Introduction." https://nccih.nih.gov/health/taichi/introduction.htm (accessed April 29, 2015).

of internal force as contrasted to external force which is emphasized in other martial arts. Tai chi incorporates the Chinese concepts of opposing forces within the body and a vital energy of life force, supporting a healthy balance of yin and yang.[117]

There are many styles of tai chi which emphasize different tai chi principles and methods. Its popularity has increased world-wide as a basic exercise program and as a complement to other health care methods. In the 2007 National Health Interview Survey, it was determined that 2.3 million US adults had used tai chi in the previous 12 months. The reasons identified for its use included 1) the benefits associated with low-impact, weight bearing, aerobic exercise, 2) to improve physical condition, muscle strength, coordination and flexibility, 3) to improve balance and decrease the risk of falls, 4) to ease pain and stiffness, 5) to improve sleep, and 6) for overall wellness.[118]

Ongoing research demonstrates that tai chi can reduce stress and increase balance, aerobic capacity, and flexibility. Some studies suggest that it may be beneficial in managing conditions such as high blood pressure and depression and may improve joint pain and sleep,[119] and tai chi is credited with bringing about mental and spiritual clarity.[120]

The final example of mind-body practice explored in this thesis project is Yoga, identified as the sixth most common complementary health practice among adults in the 2007 National Health Interview Survey.[121] Yoga consists of a series of physical postures,

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[117] Ibid.
[118] Ibid.
[119] Bauer, 114.
[120] O'Mathúna and Larimore, 258.
[121] "Yoga for Health," *National Center for Complementary and Integrative Health,* https://nccih.nih.gov/health/yoga/introduction.htm (accessed April 29, 2015).

meditation, and controlled breathing exercises, also referred to as paced respirations. Practiced for thousands of years in India, the popularity of Yoga has increased in the United States in the past 100 years and may be taught at health clubs, community centers, senior citizen centers, and even Christian churches.

The word *yoga* literally means "union," and as an important part of the Hindu religion, it implies union with the "divine." For those committed to the spiritual roots of Yoga, the aim is to achieve spiritual enlightenment, thought to be achieved through the integration of the physical postures and breathing exercises. The physical postures, known as *asanas,* are thought to relax the mind and body and bring them to spiritual harmony. The breathing exercises, known as *pranayamas*, are designed to regulate the flow of *prana*, the Hindu term for life energy.[122]

Through this practice a meditative state is sought, from which the Great Unconscious occurs leading to spiritual enlightenment. The apex of the enlightenment is known as "Kundalini arousal." Found in Hindu mythology, Kundalini is a serpent goddess who rests at the base of the spine. However when aroused, Kundalini travels up the spine activating a person's *prana* and clearing the person's *chakras* (energy transformers). Ultimately the head *chakra* is reached by Kundalini which opens the practitioners to enlightenment from occult sources and spirit guides.[123]

For many, Yoga is not a religion; it is merely a group of exercises whose aim is to improve strength, balance, and posture and flexibility.[124] The mind-body technique also

[122] O'Mathúna and Larimore, 271.
[123] Ibid.
[124] Bauer, 13.

aims to assist the participants achieve complete peacefulness of mind and body as they are encouraged to be aware of their body, how they feel with particular postures, and focus on breathing.[125] Yoga has been found to potentially reduce low back pain and improve function, reduce stress, lower heart rate and blood pressure, help relieve anxiety, depression, and insomnia as well as improve overall fitness, strength and flexibility.[126]

## Integrative Medicine

Integrative medicine is a developing concept in the health care system, affecting hospitals, universities, and medical schools. While a variety of definitions are used, the foundation of integrative medicine is bringing conventional (allopathic) and complementary medicine approaches together in a coordinated way.[127] Integrative medicine is more than just combination medicine, adding complementary therapies to conventional medicine. "Integrative medicine represents a higher-order system of systems of care that emphasizes wellness and healing of the entire person (bio-psych-socio-spiritual dimensions) as primary goals, drawing on both conventional and complementary approaches in the context of a supportive and effective physician-patient relationship."[128] Prevention as a means of enhancing health and well-being are

[125] Laura Malloy, "Pill-free way to Reduce Pain and Improve Balance and Flexibility," *Harvard Health Letter* (March 2014).

[126] "Yoga for Health."

[127] "Complementary, Alternative, or Integrative Health: What's in a Name?"

[128] Iris R. Bell, Opher Caspi, Gary E. R. Schwartz, Kathryn L. Grant, Tracy W. Gaudet, David Rychener, Victoria Maizes, Andrew Weil, "Integrative Medicine and Systemic Outcomes Research: Issues in the Emergence of a New Model for Primary Health Care," *Achieves Internal Medicine* 162 (January 28, 2002): 133.

accomplished through physical activity, nutrition, screenings, stress management and spirituality.[129]

An individual is more than just one's physical body, and treating only the physical body does not allow for complete healing.[130] A central tenant of integrative medicine is the body's innate ability to heal; healing originates within the patient not the physician. Conventional and complementary modalities are used to facilitate healing and to empower the patient.[131]

While conventional medical approaches may respect the religious and spiritual beliefs of a patient, they often focus on a specific somatic disease and disease process. The comprehensive care system of the alternate integrative medicine model views the individual person as a whole and recognizes the impact that the mind, body, and spirit have on a patient's state of health.[132] Through the integrative medicine approach, the patient and physician form a partnership treating the mind, body, and spirit concurrently.[133] Contemplating the meaning of illness for a patient may serve as an agent for change and for healing. Additionally the integrative medicine model purports that the experience of a therapeutic relationship facilitates the healing process.[134]

Good medicine is grounded in good science, and this extends to the practice of integrative medicine. Integrative medicine utilizes therapies which have support of some

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[129] Victoria Maizes and Opher Caspi, "The Principles and Challenges of Integrative Medicine," Western *Journal of Medicine*, 171 (September 1999): 148.

[130]Teresa Sievers, "Universal Life Force," *èBella* (March 2015), 44-45.

[131] Maizes and Caspi, 148. Bell, Caspi, Schwartz, Grant, Gaudet, Rychener, Maizes, and Weil, 134.

[132] Bell, Caspi, Schwartz, Grant, Gaudet, Rychener, Maizes, and Weil, 134.

[133] Katherine Kam, "What is Integrative Medicine?" http://www.WebMD.com/a-to-zguides/features/alternative-medicine-integrative-medicine#2 (accessed October 14, 2016).

[134] Maizes and Caspi, 148.

high quality evidence,[135] whether the source of practice is conventional or complementary. Therapeutic modalities which may be found in integrative medicine practice include, but are not limited to, herbal medicine, acupuncture, massage, biofeedback, Yoga, and stress reduction techniques. What works, and what does not work are the subject of inquiry as researchers continue to look at the safety and effectiveness of complementary and alternative therapies used in integrative practice.

Integrative medicine centers continue to gain popularity in the United States. In 1998, approximately 8.6% of the hospitals in the United States offered complementary therapies, however, in 2004; this number was approximately 20%. An additional 24% of hospitals include complementary medicine in their future plans.[136] One reason fueling the development of the integrative medicine model is the dissatisfaction of many with the high cost of conventional medicine and decreased health care coverage which may also be present.[137] Another motivating factor is the potential of more time, attention, and a broader approach to healing for an individual which draws on both the Western model and approaches of other cultures.[138]

The interest and increasing practice of integrative medicine has also influenced medical education as medical schools have added courses on non-traditional therapies. For instance, the University of California offers medical students the option to include the

[135] Kam.
[136] Ibid.
[137] Sievers, 44. Bell, Caspi, Schwartz, Grant, Gaudet, Rychener, Maizes, Andrew and Weil, 135.
[138] Kam.

study of herbs and dietary supplements with the study of infectious disease and immunology.[139]

Support for integrative medicine is not universal. Some suggest that the expansion of integrative medicine is driven by market forces and public fascination and demand for alternative treatments. Others express concern that available scientific conclusions do not justify the amount of resources spent for integrative medicine.[140]

## New Age Practices

A precise definition of the term *New Age* has been difficult to establish as the term has been used to include many beliefs, practices, and ideas as well as a variety of people and organizations, although there is no recognized leadership or base. Attracting participants from different life strata, this movement has been practiced in the United States, Europe, Asia, and Africa. The diverse objectives of the movement transverse the areas of holistic health, politics, science, religious cults, and psychology, and the movement has spread through exposure in film, television, art, literature, and politics.[141]

Unable to trace the exact origin and trajectory of the movement, many New Age practices and beliefs are thought to have originated in Theosophy and New Thought, and nineteenth century works of Franz Anton Mesmer and Emanuale Swedenborg. Mesmer and Swedenborg's ideas of "universal brotherhood and comparative religion," the work

[139] Ibid.

[140] Kam.

[141] K.A. Adam Chepkwony, "New Age Movement: A Challenge to the Church in the 21st Century," *African Ecclesial Review* (December 2006): 313.

of Abraham Maslow's on "self-actualizing individuals," and the work of transpersonal psychologists laid the foundation, for the "human potential movement" of the 1950's and 1960's. Concepts from the aforementioned theories fused with understandings rooted in Eastern religions contributed to the development of the New Age movement of the 1970's and 1980.[142]

The dawn of the movement is also traced to astrological roots. Some argue that for the last 2000 years the sun has been in the constellation of Pisces (fish), however, the sun began to move into Aquarius (Water Bearer) at the end of the 20th century, signaling a spiritual change. It is projected by New Age understanding that although Christianity has been the predominant religion for the last two millennia, this shift is expected to give rise to a more universal spirituality of Aquarius age, the new Age Spirituality.[143]

While some perceived the movement of as a new religion, others understood that the movement was directed toward the esoteric/metaphysical/Eastern groups and to the mystical strains in all religions. Transformation of self through various activities such as channeling, crystals, natural diets, astrology, body work, and healing were emphasized.[144]

Self-transformation was not the only focus of this movement. Economic, social and cultural transformation was also encouraged. The movement offered a new way of approaching one's self and the world; the goal was societal transformation. It has been

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[142] Daniel P. Mears and Christopher G. Ellison, "Who Buys New Age Materials? Exploring Sociodemographic, Religious, Network, and Contextual Correlates of New Age Consumption," *Sociology of Religion* 61 no. 3 (2000): 290-291.

[143] Chepkwony, 314-315. While this thesis-project is intended to provide an overview of the various constructs, Chepwony provides additional astrological correlations cited by New Age movement writers.

[144] Mears and Ellison, 291.

suggested the New Age Movement was the impetus of the liberation movements of the 1960's in the United States.[145]

The label *New Age* cannot be defined as a homogenous category with one doctrine, or set of practices and beliefs. However, shared features and principles are found among the New Age ideologies. First, there is a conviction that the earth and its peoples are on the verge of a spiritual transformation. Second, the movements include a wide variety of healing practices such as meditation practices, Yoga, and trance channeling. Third, the movements include the notion a prerequisite for successful societal transformation require self-empowerment and the realization of individual goals and aspirations. Finally, the movements seek to merge religious and scientific worldviews through which the human condition would be enhanced spiritually and materially.[146]

Embracing the ideas of monism, pantheism, and autonomy, the New Age movement rejects the idea of absolutes. Truth and moral values are relative, and religion is seen, not what is true, but rather what as one likes and what one wants.[147]

Monism is the term used to reflect that everything is part of one single differentiated reality, or in other words, "all is one."[148] This principle underlies the notion we are evolving towards a single united humanity in a process known as planetization. Recognizing the non-human world is as important as human beings, the

[145] Chepkwony, 315.
[146] Mears and Ellison, 291-292.
[147] Chepkwony, 319.
[148] Ibid., 317.

importance of the restoration and preservation of ecosystems is recognized by the movement.[149]

*Pantheism*, derived from the Greek words *pan* meaning "all" and *theism* meaning "God," is the term used to describe that "all is God." This concept reflects everything is a manifestation of God. Those in the movement recognize each individual is innately divine and therefore is God. Religions are different ways of expressing the same divine reality.[150]

A universal concept of world religions is salvation. For those in the New Age movement, salvation is associated with the transformation of the individual consciousness as well as the universe. The pinnacle, or Altered State of Consciousness, is the experience of discovering who one really is with the actualization of one's divinity. Methods to achieve this state include meditation, positive thinking, music, channeling, and mind-altering drugs.[151]

## Data Collection

After approval of the Barry University Institutional Review Board was obtained, a convenience sample of faith community nurses was recruited.[152] For this thesis project

[149] Ibid.

[150] Ibid., 318.

[151] Ibid., 320.

[152] To be considered for this thesis project, faith community nurses had to meet criteria set forth by American Nurses Association and Health Ministries Association. The participant had to be a registered nurse, licensed in the state of their practice, and credentialed through an education program, baccalaureate program, or graduate nursing course. Those practicing in both paid and volunteer positions were considered.

the sample was limited to faith community nurses practicing in or retired from practice within mainline Christian Church denomination. A letter of introduction[153] provided a brief over view of the project and interview request was sent to known faith community nurses. A follow up telephone call was placed to request participation. If the participant agreed to participate, an interview was scheduled at a time and place convenient for the interviewee. Although the faith community nurses recruited were professional colleagues, the investigator had no authority over the nurses. No benefits for the participation in the study were offered.

The principle investigator met with the participant at the agreed time and place. Prior to the initiation of the semi-structured interview, the participant was provided with two copies of a consent form.[154] The participant signed and returned one copy to the researcher, and the second copy remained with the faith community nurse participant. A tool[155] was designed and used by the researcher to guide the interview process to elicit information regarding discernment processes used by the faith community nurse with respect to complementary medicine therapy recommendations. For clarification, the definition of complementary therapy, "therapy that is used as an adjunct to an established conventional medical treatment plan," was provided for the faith community for the purposes of the interviews.

[153] See appendix D.
[154] See Appendix E.
[155] See Appendix F.

## Summary of Results[156]

Twenty of the invited twenty-three faith community nurses participated in this thesis-project. Representatives of the following Christian denominations were queried: Anglican Church, Congregational Church, Episcopal Church, Lutheran-Episcopal Church, Lutheran Church-Evangelical Lutheran Church of America, Lutheran Church-Missouri Synod, Presbyterian Church USA, Roman Catholic Church, and the United Methodist Church. All engaged in face to face interviews.

The participant nurses represented a span of five months to nineteen years of practice as a faith community nurse at the time of the interview. Ten of the nurses had worked ten or more years in this nursing specialty. Fifteen nurses had paid positions, and five nurses worked as volunteers for the congregation they served. Fourteen nurses worked within their personal denomination identification, while six nurses worked for faith communities other than their personal affiliation. One nurse worked with two different denominational congregations.

The basic level of nurse preparation spanned the possibilities that include associate degree, diploma, and baccalaureate degree preparation. Twelve of the nurses had academic preparation beyond the basic level, and twelve of the nurses had obtained nurse specialty certification in another area of nursing. Although all did not have academic or specialty credentials beyond their basic level of nursing preparation, all were licensed in the state of Florida which requires continuing education for license renewal.

[156] See Appendix G for complete tabulation of raw data.

Every nurse interviewed had worked in previous nursing positions; the settings varied. Nursing practice areas included cardiac/open heart surgical care, critical care, emergency care, enterostomal therapy, gerontology, hospice and palliative care, intensive care, medical-surgical care, nursing education, oncology, physician's office, psychiatric care, public health, surgical and recovery room, and urology.

Although the level of enthusiasm for complementary medicine interventions expressed was mixed, the entire cohort agreed there was a potential for use within an individual health plan; no nurse rejected the general notion of complementary medicine therapies. "I would be open to them," was representative of a neutral position. Other nurses presented a more positive response. For instance descriptions included complementary medicine therapies "offered a lot of value, " "they (complementary medicine interventions) have been helpful providing relief and comfort for symptoms that cannot be otherwise relieved," "the mind and body connection cannot be separated," they (complementary medicine interventions) may enhance pharmaceutical benefits and other treatments," and "conventional medicine may not address needs of the individual."

Complementary medicine therapies, as a whole, garnered caution.[157] Balance between interventions and an expectation of therapy were identified as important, as well as the idea a practice may be beneficial although not curative. Research and evidence for use were necessary considerations among the nurses. The quality of the practitioner was a measured consideration. Utilization and financial ramifications of investment in a particular therapy required attention. The list of warnings for use of complementary

[157] Most of the nurses who were "unsure of an intervention" noted their assessment was based on lack of knowledge about the practice. However, effectiveness of a therapy was also questioned.

medicine therapies included, as well, the potential to damage one's psyche, and spiritual vulnerability of the participant.

The respondents identified perceived concerns[158] with the specific therapies discussed in this thesis-project. An overarching principle was lack of knowledge was a limiting factor in support of a therapy. However, specific concerns were also noted. For instance, one nurse mentioned would not support acupuncture for a client with trypanophobia (fear of needles). One respondent stated she would not support biofeedback with concern that the therapy was not professionally monitored, another nurse feared the provider might have a particular "psychological twist" which may create fear. A nurse warned healing should be attributed to God verses the energy of the universe in the practice of healing touch, another nurse was wary the practice may be "voodoo from the devil." Reflexology elicited responses of disbelief in the practice itself and lack of therapeutic value. An interviewed nurse was involved in Reiki training but became concerned that the practice did not identify all power as God's power, and discontinued participation in the training. Another nurse cautioned that the client would need to recognize "God's energy in the nurse's hands," and another nurse found the concept to "not be of our Lord," therefore foreign to Christian principles. Tai chi was endorsed as an exercise with the warning it should not be associated with an eastern philosophy. Similarly, Yoga was presented as good for balance, however not for use with a religious basis.

[158] The concerns were identified in this thesis project as "perceived" as they were the concerns of the individual nurse, but not necessarily supported by literature.

The interviewees were asked about denominational declarative statements with respect to complementary therapies and if particular church guidelines for therapy existed. If the nurse stated "yes" or "no," these responses were tallied in the definitive column. Responses such as "I am not sure" or "I don't know," were tallied in the unsure column. Although nurses may have been unaware of specific denominational or community missives, several nurses were alert to the sensitives of the particular faith community leadership, deferring to leadership preferences. Several nurses commented their pastors provided support for complementary therapies and one pastor personally utilized complementary therapy treatments. Four of the pastors had medical backgrounds; two were physicians, and two were paramedics.

A range of resources for knowledge acquisition by the faith community nurses included professional, popular, and personal sources.[159] Professional peer reviewed journals were accessed such as the *American Journal of Medicine* and *Journal of Christian Nursing.* Online resource use included National Institutes of Health resources, Medscape, Medline, Mayo Clinic resources, and Cleveland Clinic resources. Faith community nurses also accessed the wisdom of other professional health providers, as well as feedback from other consumers.

As requested, the interviewees described the process they would use in discussing use of complementary therapies with a questioning parishioner. Influences which may have formed their decision making process will be discussed in Chapter 3. The information received through the interviews coupled with the protocols/norms which

[159] The resources identified in this section are not inclusive of all identified by the faith community nurses interviewed, but are a representative sample.

should be considered in decision making are explored in Chapter 4 and will form the basis of Chapter 5 which will suggest a praxis to be used by faith community nurses for evaluation of complementary medicine modality usage.

# Chapter 3

## Why is This Being Done: Analysis of Current Praxis of Faith Community Nursing Considerations with respect to Professional and Theological Considerations

This thesis-project is located within the discipline of practical theology. The second core task of practical theology is to understand and explain the patterns and dynamics of a particular situation drawing on theories of arts and sciences. This is process is referred to as the *interpretive task.*[1] This task requires the evaluator recognize relevant particulars of a specific event and circumstance, determine the moral ends of concern, and determine the most effective means of action recognizing the spheres of influence. Through this process, the interpreter needs insight into the particular circumstances of the situation, recognizing reality is complicated by the complexity of people and events which may not fit ideally into theory. The interpreter must also select the best theory for the situation under investigation, although many theories may be available.[2]

Sociological factors of medicine and religion provide a backdrop for the actions of the faith community nurses and their decision making process. Faith community nursing intersects the aforementioned domains where leadership historically has been male, while females played supportive roles. Although the evolution of nursing,

[1] Richard R. Osmer, *Practical Theology: An Introduction* (Grand Rapids, MI: William B. Eerdmans Publishing Company, 2008), 4.

[2] Ibid., 80, 82- 84.

historically a predominantly female occupation,[3] has moved along the continuum from a deferential position within the medical model toward a professional position working in a collegial manner with other medical professionals, remnants of nursing's subservient history may remain.

Today, in some faith traditions, lay leadership is encouraged by the baptized and some traditions allow for ordination of females. Yet, other faith traditions restrict participation in ministry by gender and limit ordination to males. These historical roots and traditions may continue to influence the decision making process of the present day faith community nurse.

Those interviewed for this thesis project were members of the faith community nurse cohort. However, responses varied, demonstrating both similarities and differences with respect to the use of complementary therapy, the specific therapies investigated in this project, and the decision making process for the determination as to support or refute the use of a complementary therapy. This chapter will explore theory that may add understanding to the responses by the faith community nurses interviewed. Thoughtful exploration of factors contributing to the responses in concert with the results of the normative task, discussed in chapter 4, will provide the foundation for the development of a suggested praxis for discernment of an ethical response with respect to complementary medicine therapies.

Attempting to delineate the lines between the pastoral aspects and the nursing aspects of faith community nursing is much like attempting to divide a person into bio-

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[3] Linda C. Andrist, "Weaving Critical Threads Through Nursing Ideas," in *A History of Nursing Ideas,* eds. Linda C. Andrist, Patrice K. Nicholas, and Karen A. Wolf (Boston: Jones and Bartlett Publishers, 2006), 1.

psycho-social-spiritual entities. It is not possible. Like the body, faith community nursing is a dynamic practice, intertwining pastoral and nursing considerations. Recognizing the fallacy of a complete distinction between pastoral and nursing actions, this section will analyze themes elicited from interviews of the faith community nurses respondents in this thesis group. It should be noted that the themes identified do not occur in isolation. For organizational purposes, this thesis project will explore possible influences on the faith community nurse from a nursing perspective followed by pastoral considerations, recognizing that no such delineation is completely possible.

## Professional Nursing Considerations

### Nursing within the Medical Community

Issues in and of nursing have been linked to the issues of women. Nursing has mirrored the paradox of women's work. The work is invisible, devalued, and underpaid, yet the work is critical for society.[4] Nursing has been in the shadows of the medical profession, working ultimately under the direction of a physician, for most of its history. At the same time, the medical profession (physicians) has been predominately male throughout most of its history.[5]

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[4] Ibid., 5, 9. The early hospital training programs fostered total loyalty of the students, producing a docile, loyal, dedicated, submissive, and cheap workforce.

[5] Arnold S. Relman, "The Changing Demography of Medical Profession," in *The Social Medicine Reader* Edited by Gail E Henderson, Nancy M. P King, Ronald P Strauss, Sue E. Estroff, Larry Chruchill, 263, Durham: Duke University Press, 1997. In the United States, the medical profession was primarily white male until the 1970's when a rise in female medical school applicants was seen. In the 1969-1970 the female composition of first year medical students was 9% as compared to 38% in the 1989-1990 academic year. There has been a decrease in white male applicants to medical schools in the United States. In the late 1980's 2/3 of those entering medical school were white men, and in 1988-1989 the rate was 48%. The trend is towards a majority composition of men from racial minorities and women.

The values of nursing are often missed in patient care, because the values of medicine and the medical model have been accepted as the standard, and nursing identity has been incorporated under medicine which claims all of health care as its sphere. In some cases, medicine controlled the environment, and nursing assumed the tasks that physicians did not want to do.[6]

The relationship between the physician and nurse is long standing, and may be seen in the following example from the 17th century. Vincent de Paul established Ladies of Charity, a group initially comprised of wealthy women who provided nursing and spiritual care to the sick in their own homes. To support this mission, de Paul later recruited young ladies who were known as Daughters of Charity and "Rules of Parish Sisters" were instituted to offer guidance to the Daughters. Rule number eight read, "Remedies for the sick is the role of the physician,"[7] reflecting the relationship between physician and nurse.

Nursing's trajectory has also been influenced by its reputation, as nursing has not always been viewed as an honorable profession for women. For example, Florence Nightingale, a preeminent figure of nursing history and often considered the matriarch of modern nursing, came from a family of wealth and social ambitions. Although Nightingale had witnessed poverty and ill health of the poor, she struggled to find a path for her passion to work in nursing. While Nightingale desired a meaningful vocation, she faced the challenge of the state of the nursing of middle 19th century England; nurses

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[6] Susan Jo Roberts, "Oppressed Group Behavior and Nursing," in *A History of Nursing Ideas,* eds. Linda C. Andrist, Patrice K. Nicholas, and Karen A. Wolf (Boston: Jones and Bartlett Publishers, 2006), 23.

[7] Phyllis Ann Solari-Twadell and Karen Egenes. "A Historical Perspective of Parish Nursing: Rules for the Sisters of the Parishes." Ed Phyllis Ann Solari-Twadell and Mary Ann McDermott. St. Louis: Elsevier Mosby, 2006. 11-14

often came from the strata of the poor and unskilled, frequently accompanied with the reputation of drunkenness and immoral conduct.[8]

One argument for the subordinate station of nurses within organized medicine may be explained by the theory of nurses as an oppressed group. The cycle of oppression, first described in writings about colonized Africans, South Americans, African Americans, Jews, and American women, is rooted in the learned belief by those dominated, they are inferior. Although this belief is incorrect, it is developed as the dominant group creates norms and values for the culture in its own image, and maintains the power to enforce the norms. The subordinate group learns to devalue its own attributes as the attributes are not valued. Characteristics develop in powerless groups such as lack of self-esteem, poor communication, horizontal violence, intergroup rivalry, lack of group pride, and inward aggression, and these characteristics which serve to enhance survival under domination, have been documented within nursing.[9]

An illustration of this oppression may be seen in the early organized training of nurses at the turn of the 20th century. Sociologists note that medicine was a dominant

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[8] Barbara Montgomery Dossey, *Florence Nightingale: Mystic, Visionary, Healer*, (Springhouse, PA: Springhouse Corporation, 2000), 49, 53. Patricia Maher, "Reclaiming Spirituality in Nursing," in *A History of Nursing Ideas*, eds. Linda C. Andrist, Patrice K. Nicholas, and Karen A. Wolf (Boston: Jones and Bartlett Publishers, 2006), 417, 419-420. Women of that period joined religious orders with the charism of healing; Nightingale envisioned nursing as mystical work which was not to be done through withdrawal from the world, but through action in the world. Action of the nurse was not to pray that God would act, but the nurse should act to reduce poverty and sugaring and improve the health of the community.

[9] Andrist, 23, 25, 31. For instance, workplace bullying is viewed as a significant issue facing the nursing profession, which is frequently described in terms of 'oppressed group' behavior or 'horizontal violence'. However, it should be noted that workplace bullying is not unique to nursing, which exists in most, if not all workplaces. Depression, anxiety, and post-traumatic stress disorder are added to the characteristics listed above. Marie Hutchinson, Margaret Vickers, Debra Jackson, and Lesley WIldes, "Workplace bullying in nursing: Towards a More Critical Organizational Perspective," *Nursing Inquiry* 13, no. 2 (May 15, 2006): 118-119.

force and the care of the sick became institutionalized.[10] Physicians often argued against the teaching of theory to nurses. One physician explained a tendency of trained nurses to interfere in the conduct of medical and surgical cases; they (nurses) hint that prescriptions and treatment may require amendments, and suggest diagnosis and prognosis. At the same time, nursing leadership failed to conceptualize organized medicine and hospital administrators impeding the growth of nursing as an autonomous profession, as women had no political freedom, little legal status, and no right to become professional people.[11]

Western society has placed nurses in the duality seen by many groups of women, and women as a whole. When the workforce required the supplementation of women, for instance during war years, the importance of women in the workforce was highlighted. However, in peacetime, nurses were to assume a subservient position, and nurses were seen distanced from "traditional" female roles. The 1950's romance novels featured nurses, not only dedicated to patient care, but imbued with romantic adventures as part of the plot line. Women's magazines exposed nursing as a wonderful way to marry a physician. During economic prosperity and growth, nursing failed to attract women who needed or wanted to work, as salaries were less than that of a typist, librarian, or seamstress, and rigid and subordinated roles were not appealing. Although the issues of pay and job equity and the nurse-physician relationship impacted both women as a whole

[10] Roberts, 25. Nurses were viewed as inexpensive labor, and they worked long hours under difficult conditions with poor pay. Maher, 420.

[11] Andrist, 11.

and nurses as a subset, many nurses failed to see the relationship due to the strong socialization they had received during their training as nurses.[12]

Another potential influence in the development of nursing posed is the predominance of women, and qualities attributed to female, in the profession. Expressive roles attributed to femininity such as nurturing, caring, dependence, and submission are counter to the instrumental masculine traits such as aggression, self-control, competitiveness, and dominance.[13]

Caring is a human response to suffering and it is foundational to the nursing ethic.[14] Proclamation of this notion may impact nursing negatively, depending on the understanding of the construct of caring. *Ordered caring*, polarizes caring and power as opposites. *Assimilated caring* changes the power relationship as nurses assimilate to the dominant values, however it remains a power over another. *Empowered caring* involves embracing caring and the intrinsic power it holds; encompassing social, economic, and political determinants of health. *Empowered caring* is a tool not to amass power, but to create social and cultural change. Embracing the concept of *empowered caring* holds the

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[12] Ibid., 15, 17-18. Janet Muff, in her book *Socialization, Sexism, and Stereotyping in Nursing (1982)* argued that nurses are affected both by their female socialization and by the social, political, and psychological issues inherent in nursing and the health care system.

[13] Ibid., 10. Mills School of Nursing for men at Bellevue Hospital opened in 1888; however this training was not widely replicated. And men were not admitted to female training schools until after the Korean War. Joan Evans, "Men Nurses and Women Physicians: Exploring Masculinities and Gendered and Sexed Relations in Nursing and Medicine," in *A History of Nursing Ideas*, eds. Linda C. Andrist, Patrice K. Nicholas, and Karen A. Wolf (Boston: Jones and Bartlett Publishers, 2006), 35-36. In 2003 approximately 5.3-5.4% of nurses were male. The failure of an increase of men into nursing, as seen with the shift of women into the role of physician, was attributed to fear of being subordinate to women, nursing's threat to men's self-esteem and masculinity, and nursing's low salary and lack of occupational prestige.

[14] Maher, 422.

potential to empower nurses, to empower women, and eventually to empower all people.[15]

Despite societal changes which have allowed women to enter into traditionally male positions, nursing has remained a quintessential feminine occupation.[16] Although a fairly recent development with respect to the historical continuum, there has been an increased presence of women in medicine and hospital administration.[17] Additionally, the nurse-physician relationship is changing, which is attributed to the feminization of medicine, changing ideas about nursing and nursing autonomy, the socialization of nursing students to assume a more professional role, as well as the presence of men in nursing.[18]

Nursing today continues with vestiges of its history. Although feminist theory and philosophy have permeated nursing scholarship, practice, and education since the mid-1980's,[19] one might ask the universal impact of the change, and its acceptance by those who were socialized and trained in nursing prior to the curricula augmentation. Nurses continue to articulate that the physician-centered atmosphere of the health care system disregarded decisions made by nurses. It was often expected that nurses were expected to intervene, however, they were not to intervene independently, they were

[15] Andrist, 19-20.
[16] Evans, 35.
[17] Andrist, 2.
[18] Evans, 40-41.
[19] Andrist, 19.

expected to obey.[20] A study conducted in the 1990's revealed that nurses felt devalued and viewed as "handmaidens."[21]

Although the faith community nurses do not work in a typical health care institution, following physician orders per se, the medical model culture may continue to influence the behavior of the faith community nurse. The authority once wielded by a health care institution in which the faith community nurse practiced, may now be managed by the faith community leadership. Faith community nurses may not be inclined to challenge the perceived boundaries established within the faith community.

*Nursing Process*

A popular saying reflects one aspect of the nursing profession. That is, "A nurse is a nurse." As with other sayings, this is based on a kernel of truth.

Formalized nursing education has evolved since its inception in the 1800's when many hospitals established training programs to prepare nurses for their own staffing requirements. Training schools differed in content and length of training, as the focus of training was concerned with the needs of the hospital, availability of physicians and nurses, and available resources. This variability in training led to the conclusion that a consistent minimum standard of practice across clinical settings was necessary.[22]

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[20] Mohsen Abid Hagbaghery, Mahvash Salsali, and Fazlolah Ahmadi, "The Factors Facilitating and Inhibiting Effective Clinical Decision-making in Nursing: A Qualitative Study," *BMC Nursing* 3, no. 2 (2004). http://www.bopmedcentral.com/1472-6955/3/2. Accessed June 5, 2017.

[21] Roberts, 25.

[22] Hinton, Sharon, "History and Philosophy of Faith Community Nursing, *Foundations of Faith Community Nursing Curriculum,* (Memphis, TN: International Parish Nurse Resource Center, 2014): 7. The New England Hospital for Women and Children at the New England Hospital for Women and Children was the first hospital in the United States to offer formal nursing training, graduating the first nurses in 1873. Andrist, 9.

Clinical practice education standards have been developed, and professional nurses, with specialties ranging from obstetrics to hospice, are steeped in the construct of the nursing process. No matter the basic professional nursing education model, the initial curriculum includes teaching the nursing process.

The nursing process is adapted from the scientific method. When first described by Ida Jean Orlando in 1958, the nursing process included four steps which included assessment, planning, implementation, and evaluation. The nursing process was more deeply embedded as nursing advanced its practice scope and standards through the development of nursing diagnosis and nursing interventions. In 1982, the North American Nursing Diagnosis Association, now known as NANDA International, was founded to develop research, disseminate, and refine the nomenclature, criteria, and taxonomy of nursing diagnosis.[23]

The assessment phase of the nursing process involves both subjective and objective data collection. Best practice utilizes an established evidence based framework for accuracy. Data collection creates the foundation for establishing the nursing diagnoses of actual or potential health problems occurring with the individual, family, group, or community. The nursing diagnosis is then used to drive the implementations included in the nursing care plan to the desired outcomes identified in the planning stage.

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[23] *NANDA Nursing Diagnosis Source Information*. https://www.nlm.nih.gov/research/umls/sourcereleasedocs/current/NAN/. Accessed June 4, 2017. Noreen Cavan Frisch, "Nursing as a Context for Alternative/Complementary Modalities," in *A History of Nursing Ideas*, eds. Linda C. Andrist, Patrice K. Nicholas, and Karen A. Wolf (Boston: Jones and Bartlett Publishers, 2006), 431, 432. NANDA taxonomy is an atheoretical statement of nursing problems and concerns or nursing diagnosis. The nursing diagnosis then drives nursing interventions (NIC) towards nursing outcomes (NOC). Complementary therapy interventions become part of the nursing process, the documentation of nursing assessments, concerns, interventions, and outcomes.

The nurse then evaluates the progress towards the identified outcomes, making changes as necessary.

The nurses interviewed in this thesis-project unanimously articulated the general sense of the nursing process as they considered the process they would use for discussing with a congregant the potential use of a complementary medicine therapy. The nurses expressed conversation would begin with collecting information from the parishioner including the reasons for the potential use of the complementary therapy and the expectations of the therapy. Information gathering would also include the client's understanding of evidence behind the therapy, both informal and formal. The nurse would also extend the information pool with evidence from reputable sources, as necessary.

Several of the nurses were deliberate expressing they do not tell the clients what should be done, they are not prescriptive.[24] Rather, the faith community nurse would discuss the options with the client and support the client is establishing an individualized plan for action. This plan considers influencing variables such as availability of credentialed/trained providers, transportation requirements, and financial concerns.

The nurses expressed the process used with an individual questioning the use of complementary medicine was generally consistent with the process used with

[24] This action is consistent with the findings of The Institute of Medicine which defined a fundamental approach to improving patient care in the United States, patient-centered care. Patient-centered care is "care that is respectful of and responsive to individual patient preferences, needs, and values", and ensures the patient "values guide all clinical decisions." This recommendation emphasizes the importance of clinicians and patients working together to achieve the best outcomes. Patient centered care enables a informed client to make a decision without the label of "wrong" by the clinician who may have difference values and preferences. Michael J. Barry and Susan Edgman-Levitan, "Shared Decision Making-The Pinnacle of Patient-Centered Care," *New England Journal of Medicine* 366 (March 1, 2012): 781-782.

conventional medical queries. However, six of the nurses in the sample indicated an increased sense of caution when considering a complementary therapy referral.

*Clinical Decision Making*

The argument that nursing decisions impact patient outcomes is not a new idea. However, there has been a trajectory of increasing active decision making on the part of nurses as a member of the health care team and in terms of setting policy. Evidence-based decision making, a prescriptive approach for sorting choices based on the ability of theory to improve decision making in concrete situations, requires nurses to access, appraise, and incorporate research evidence into their professional judgment and clinical decision making.[25]

Recognizing that research is based on "information need," which is determined by the person "in need" and influenced by individual motives,[26] British researchers explored active engagement with research evidence by nurses in a variety of settings. Decision making was a complex activity, which was influenced by the time available to make the decision, competing goals, and conflicts among decision making participants. The study presented two conclusions with respect to the information behavior of the nurses studied: there was a preference for human information sources, and useful information sources

[25] Carl Thompson, Nicky Cullum, Dorothy McCaughan, Trevor Sheldon, and Pauline Raynor, "Nurses, Information Use, and Clinical Decision Making-the Real World Potential for Evidence-based Decisions in Nursing," *BMJ* 7, no. 3 (2004). http://bmj.com/content/7/3/68.full. Accessed June 5, 2017.

[26] Ibid. Motives may be seen as the reasons for information gathering. For instance, one reason for research based information is to reduce clinical uncertainty, or finding relevant research to produce an identified outcome. The use of research may be used to confirm existing information, beliefs, and values and to support existing practice. The process of searching for, appraising, and integrating research information with existing knowledge is known as "information behavior" in the field of information science.

were grounded in clinical reality. Colleagues were viewed as useful and accessible sources of information which was context specific, clinically relevant, and efficient.[27]

Patient outcomes are contingent on effective decisions, and competent decision making by a nurse is influenced by more than just available facts and figures. For instance, personal characteristics of the decision maker affect clinical function and decision making. Feeling competent, being self-confident, organizational structure, nursing education, and being supported were also important elements in decision making according to thirty-eight Iranian nurses who participated in a study which involved both semi-structured interviews and observation.[28]

Competence and self-confidence were related yet distinct attributes. Competence included knowledge, skills, experiences coupled with the ability for proper utilization. This study of Iranian nurses supported the previous British study that effective clinical decision making included one‘s ability to gather, understand, and integrated data with a focus on the client’s needs. Self-confidence precipitated self-reliance, self-efficacy, and self-assertiveness in response to necessary implementation of appropriate care.

External forces were influential in clinical decision making. Although the Iranian nurses surveyed did not necessarily feel supported, support was considered an essential component of decision making skill acquisition. Frustration ensued when upper level support was required for a decision made, yet not received. Other barriers of clinical

[27] Ibid.

[28] Hagbaghery, Salsali, and Ahmadi. Organizational structure will be discussed in the next section concerning pastoral considerations.

decision making included lack of emotional and legal support. Nurses are reluctant to assume responsibility and engage in decision making when feeling unsupported.[29]

Another variable in clinical decision making was organizational structure; the structure and culture of a health care system. Structure involves the rules and regulations which outlines boundaries of authority, a pre-requisite for clinical decision making.[30]

Not any of the faith community nurses interviewed for this thesis-project rejected the notion of complementary medicine. Nor, did the faith community nurse accept all the complementary medicine therapies without consideration. Complementary medicine therapies in general elicited concerns of evidence supporting the therapy, financial concerns, the placebo effect, the effect on conventional medicine treatments, and the need to balance expectations and interventions. A factor in the decision not to recommend the use of a complementary medicine therapy was often associated with the lack of knowledge on the part of the faith community nurse.

Evidence, both informal and formal, was a part of the decision making process by the faith community nurses interviewed in this thesis-project. Informal evidence, or human information resources, including personal experience, anecdotal experience of others in the form of treatment response, and individual practitioner performance was considered in the therapy exploration. Additionally, the faith community nurses cited the use of formal evidence, which included, but not limited to, *The American Journal of Medicine*, *Journal of Christian Nursing*, *The National Holistic Nursing Curriculum*, resources from the National Institute of Health and the Centers for Disease Control, Mayo Clinic resources, Medline, and Medscape.

[29] Ibid.
[30] Ibid.

## Pastoral Considerations

### *Women as Ministerial Professionals*

Attempts to precisely define ministry has been an elusive endeavor, the origin and history of the construct of ministry is complex. Ministry is comprised of many functions, yet ministry is more than an amalgamation of the various functions.[31] Ministry is viewed differently across faith traditions, and within faith traditions. Ministry is seen as both universal and particular. It is described in terms of levels such as general ministry, publically recognized ministries, and ordained ministries. Ministry is defined by characteristics which include doing something, for the advent of the kingdom, in public, on behalf of a Christian community, which is a gift received in faith, baptism, and ordinations, which is an activity with its own limits and identity within a diversity of ministerial actions.[32] Some distinguish between Ministry and ministry. While others differentiate between general ministry rooted in the gifts of the Holy Spirit bestowed on the members of the faith community and the ordained ministry.[33]

The present ministerial structure of Christian churches is not found in the New Testament and there has not been a smooth and systematic development throughout Christianity; ministry has not been limited to the ordained, nor has the organizational structure been fixed. Research of the first century Christianity ministry revealed great variance: there were a variety of ministries, a combination of ministries, and a diversity

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[31] Richard P. McBrien, *Ministry: A Theological, Pastoral Handbook,* (Sam Francisco: Harper & Row Publishers, 1986), 7.

[32] Ibid., 8-9. Definitions by Edward Schillebeeckx, O.P., Yves Congar, O.P., and Thomas O'Meara, O.P, twentieth century Catholic theologians, are cited by McBrien.

[33] Ibid., 9-10.

of ministerial structures. Ministry of the post-biblical church was influenced by a combination of politics as well as theology and the inspiration of the Holy Spirit.

Division between the laity and the clergy began to develop in the fourth century, and the crevasse widened in the Middle Ages with the establishment of the *ordo clericorum* and the *ordo laicorum.* The Church as a hierarchy was the perpetuated by the Council of Trent and the post-Reformation Catholic Church, which afforded bishops and priests special spiritual powers and authority, and mandate for service fell in importance.

The role of women in the church has also changed through the course of Christian history to varying degrees; and no consensus has been achieved. With varying degrees, women as participants in ministry have been noted from the New Testament era to present day. The first centuries of the early Church had women in positions of apostles or deaconesses. Later, in the twelfth century, the activity of religious women continued to support the church, first in cloisters. In the seventeenth century, the cloistered form of life was combined by active ministry, and women religious were permitted to work in education and health care. In the early 1970's women outside religious congregations were participating in ecclesial ministries.[34]

While the Second Vatican Council hoped to sway ministerial belief to include service, the teachings were equivocal. Documents reflected that all were to participate in the priesthood of Christ by virtue of baptism and confirmation, while the degree and essence of participation were different between the common priesthood of the baptized

[34] Thomas F. O'Meara, *Theology of Ministry, Revised Edition* (New York: Paulist Press, 1999), 29-30.

and the ministerial priesthood of the ordained.[35] Throughout most of Christian history, direction of the Church, especially the Roman Catholic Church, has rested in the sphere of the ordained, and the ordained have been generally male.[36]

In some arenas, interpretation of scripture passages,[37] have complicated the matter of understanding ministry, influenced ministerial leadership, created controversy, and have been used to limit the roles of women in the church and ministry.[38]

The way in which the role of women is viewed influences the possibilities for participation within a faith tradition. Four predominant views have been categorized: the traditional view, the complementarian view, pluralism, and the egalitarian view.

The traditional view with respect to women's role in the church sees that male and female are different and were created from the beginning for different roles. Simply stated, Man was created in the image of God and was to lead and have authority, and Woman was to be "Man's helper." Those that follow this thought see the Bible as

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[35] McBrien, 27, 29-30, 33, 38, 42-43. In 1972 *Minsiteria Quaedam,* the apostolic letter by Paul VI reserved "order" to bishops, presbyters, and deacons, and introduced the official lay ministries of acolyte and lector achieved through installation, not ordination. The rites of acolyte and lector have been celebrated almost exclusively in seminaries, en route to diaconal ordination. These ministries have not been open to women, nor widely used in the United States. Edward P. Hannenberg, *Ministries: A Relational Approach* (New York: The Crossroad Publishing Company, 2003), 160, 184, 188.

[36] As previously noted, some mainline Christian faith traditions allow for the ordination of women. For instance, the Lutheran Evangelical Church of America, the Episcopal Church, and the Methodist Church are examples. The theory of oppressed groups discussed earlier in the chapter may offer insight as to the effect of the male dominated order of the ordained on both the lay population as well as the female population within Christianity.

[37] For example, 1Timothy 2:11-15, "A woman must receive instruction silently and under complete control. I do not permit a woman to teach or to have authority over a man. She must be quiet. For Adam was formed first, then Eve. Further, Adam was not deceived, but the woman was deceived and transgressed. But she will be saved through motherhood, provided women persevere in faith and love and holiness, with self-control." Senior, Donald, ed. *The Catholic Study Bible: New American Bible*. (New York: Oxford University Press, 1990), 335

[38] Steve Calagna, "Women and Ministry" (Theological position paper, The Kings Seminary (February 24, 2003), 2.

supporting the role of men to lead society, the church, and family, and women are to be subordinate.[39]

The male leadership view, also known as the complementarian view, is similar to the traditionalist view. This model interprets the creation story slightly differently; Woman was seen to be created in the image of God, as well. Woman is seen as equal in nature to Man, but differentiated roles are assigned. Men retain authority and Woman will find fulfillment in submitting to that authority.[40]

Pluralism recognizes that Man and Woman were both created in the image of God, yet neither project the fullness of that image. At the time of creation, both shared equal authority, leadership, and mutual submission; male dominance was a result of the fall. However, the effects of the fall were reversed by Christ and the cross. Pluralism leads to the deduction that the call to ministry is dependent on the gifts of the Holy Spirit, not gender.[41]

The final popular thought on gender strata is the egalitarian view of the relationship between Man and Woman. Those that follow this school of thought see God found in both Man and Woman, and negate the thought that the creation story establishes a male hierarchy; male hierarchy is a result from the fall. However, Christ's life and ministry displayed a restorative attitude toward women, and the Spirit brought a new

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[39] Ibid., 3.

[40] Ibid., 4.

[41] Ibid. " A Declaration on the Question of the Admission of Women to the Ministerial Priesthood" (*Inter Insigniores)* in 1976 reaffirmed the traditional Roman Catholic Church teaching that reserved ordination to men, citing the teaching's faithful example of Christ and its consistency with the church's tradition. An exclusion of women from ordination was reinforced by John Paul II's apostolic letter, *Ordinatio Sacerdotalis.* Hannenberg, 48, 51-52.

order establishing equality of Man and Woman. As with the pluralism, service is based on gifts and abilities, and not dependent on gender.[42]

The faith community nurses reflected that faith community sensibilities were considered in their practice. For instance, one faith community nurse voiced concern that some complementary modalities were "foreign to Christian principles." Another nurse noted the congregation had a healing service of the Order of St. Luke each week, however, the parish nurse was advised by the pastor she was not be involved. Another faith community nurse recognized the physical benefits of complementary therapies such as tai chi and Yoga, but did not consider them for a religious practice

However, the responses also revealed that denominational or particular church statements did not heavily influence decision making with respect to use of complementary medicine therapies. Only one nurse was aware of a denominational statement, and six were aware of particular church guidance. These responses suggest at least three possibilities. First, the use of complementary medicine therapies is not viewed as a theological/ministerial issue, and therefore, denominational or particular church direction is not required. A second possibility is the individual faith community nurse works autonomously, perhaps placing the good of the individual about denominational/particular church missives or guidance. The third possibility is faith community nurses rely on the hierarchy, the pastor or the church council, to drive decision making with respect to advising the use of complementary medicine therapies.

The response to the nurses who participated in this thesis project with respect to direction by church leadership, clergy and/or church council, may reflect the view of the

[42] Calagna, 4-5.

faith tradition in which the nurse practices. A faith tradition honoring a traditionalist point of view may have a male dominated hierarchy or history thereof, the power may be held within the clergy, and the faith community nurse may have a subordinate position. In this position, the faith community nurse may be more likely to follow the direction of the clergy.

In other faith traditions, the pastor, while spiritual leader, may engage with consultative governance. In these situations, the nurse may demonstrate independence in decision making, and rely more heavily on the scientific evidence and personal values and preferences of the parishioner seeking counsel on complementary medicine therapy.

# CHAPTER 4

## What Should be Done: Development of Norms for Praxis Which Responds to the Potential Controversies of Complementary Therapies

The third movement of practical theological interpretation is the normative task which synthesizes the praxis and theory towards the end of the development of a new praxis. In this task, theological concepts are used for the interpretations of particular situations and contexts. Additionally, ethical norms are used to evaluate and to guide practice.[1]

Complementary medicine modalities are part of the American health care landscape. Some therapies have roots which are thousands of years old, while others have developed within the last few centuries. Longevity of use does not negate debate concerning the effectiveness and spiritual concerns associated with the use of complementary therapeutic approaches in one's health care paradigm.

This chapter will examine the medical and nursing considerations which surround complementary medicine therapies as well as the professional and pastoral responsibilities a faith community nurse must consider when working with an individual. Resources will then be presented to support the faith community nurse in discerning a process to ethically determine if a particular complementary therapy modality will be supported or refuted in a particular situation. Finally, the arguments for each particular therapy will be presented.

[1] Richard R. Osmer, *Practical Theology: An Introduction* (Grand Rapids, MI: William B. Eerdmans Publishing Co, 2008), 131.

## Medical and Nursing Considerations with Associated Norms/Protocols

With an eye toward research, National Center for Complementary and Integrative Health (NCCIH) has divided complementary and alternative interventions into two classifications. Within each classification, the interventions share a set of characteristics that create similar challenges in designing rigorous and definitive clinical investigations of benefit and safely.[2] The first category includes mind and body interventions, practices, and disciplines, some of which are explored in this thesis-project. The second classification is that of natural products which includes oral and topically administered substances such as herbal medicines, botanicals, and probiotics. The discussion of the use of natural products is outside the parameters of this thesis-project.[3]

### Evidence-based Practice

Philosophical ideologies have contributed to dichotomy between sacred and secular knowledge throughout history. Sacred truth has been viewed as personal, subjective and non-empirical, while secular truth has been viewed as universal, generalized, and objective. This tension has resulted in skepticism by those who feel that God should not be "tested" while others are skeptical of the ability to accurately capture the sources for outcomes attributed to faith-based interventions.[4]

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[2] National Center for Complementary and Alternative Medicine, *Exploring the Science of Complementary and Alternative Medicine: Third Strategic Plan 2011-2015* (Washington, DC: US Department of Health and Human Services-National Institutes of Health, February 2011), 17. The agency name at the time of this publication was as cited, however the agency has been renamed National Center for Complementary and Integrative Health.

[3] For more information regarding the exclusion of natural products, see Chapter 2, pages 12-13.

[4] Mary Lashley, "Creating a Culture for Evidence-Based Practice in the Faith Community," *Journal of Christian Nursing* 30, no. 3 (July-September 2013): 159.

Practicing in an arena which connects the sacred and the secular, the faith community nurse must consider both ways of knowledge acquisition, science and faith. Consistent with the Institute of Medicine's goal that 90% of all healthcare decisions in the United States be evidence-based,[5] the American Nurses Association *Scope and Standards of Practice* require the professional nurse to be responsible to society to maintain a certain knowledge base and standard of care which necessitates evidence-based practice as a foundation to nursing practice. Standard 9 of the *Scope and Standards of Practice for Faith Community Nursing* exhorts that "The faith community nurse integrates evidence and research findings into practice."[6] To that end faith community nurses are ethically responsible to utilize current evidence-based nursing knowledge and research findings to guide practice.[7]

Evidence-based practice is thought to have evolved from evidence-based medicine whose philosophical origins extend back to the mid-19th century. Despite its ancient roots, the current evolution of evidence based medicine was re-ignited in the early 1990's.[8] Evidence-based medicine is "the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients."[9] The process of evidence-based practice implementation includes the steps of determining the

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[5] *The Learning Healthcare System: Workshop Summary Institute of Medicine Roundtable on Evidence-Based Medicine*, Olsen, Leigh Anne, Dara Aisner, and Michael J. Mcginnis, eds (Washington DC: National Academies Press, 2007): ix. http://www.nap.edu/catalog/11903.html (accessed July 9, 2016)

[6] *Faith Community Nursing: Scope and Standards*, (Silver Spring, MD: American Nurses Association, 2012), 39.

[7] Lashley, 163.

[8] Gordon Guyatt, Deborah Cook, and Brian Haynes, "Evidence Based Medicine Has Come a Long Way," *British Medical Journal* 329 (October 30, 2004): 990.

[9] David L Sackett, William M. C. Rosenberg, J. A Muir Gray, R. Brian Haynes, and W. Scott Richardson, "Evidence Based Medicine: What it is and What it isn't," *British Medical Journal* 312 (January 13, 1996), 71. Sharon Longton, "Utilizing Evidence-Based Practice for Patient Safety," *Nephrology Nursing Journal* 41, No. 4 (July-August 2014): 343.

topic of interest, gathering and appraising the evidence, incorporating the best practice recommendations in the current practice, and evaluation the outcomes. To advance the body of clinical knowledge, dissemination of findings is also important.[10]

A comprehensive approach to establishing a treatment plan is evidenced-based practice which has been shown to lead to higher quality care, improved patient outcomes, and reduced cost.[11] This model of health care, integrates the best evidence from clinically relevant well-designed studies and patient care data, and fuses the findings with clinician expertise, and patient preferences and values.[12] The weight of each of the contributing consideration is determined by the particular clinical situation.

Evidence-based practice relies on the evaluation of outcomes, and to contribute to care enhancement, results should be shared.[13] An example is seen in the work on infection control and environmental cleanliness by Florence Nightingale, a nurse, theological scholar, and writer. Nightingale conducted clinical research, kept systematic records of outcomes,[14] and then used evidence-based practice during the Crimean War of the 1850's as she associated the effects of poor hospital sanitation to the rising death rate

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[10] JoAnn Mick, "Call to Action: How to Implement Evidence-based Nursing Practice," *Nursing 2017* 47, no. 4 (April 2017): 39.

[11] Bernedette Mazurek Melnyk, Ellen Fineout-Overholt, Susan B. Stillwell, and Kathleen M Williamson, "The Seven Steps of Evidence-Based Practice," *AJN* 110, no. 1 (January 2010): 51.

[12] Ibid. Various models have been developed to integrate evidence into practice. For example, the three-circle evidence-practice model defines evidence as research expertise, clinical expertise, and patient preferences. Nurses must be able to evaluate the quality and validity of evidence and be able to introduce, develop, and evaluate the evidence in practice. The authors suggest the terminology of "evidenced-based practice" rather than differentiating various practice areas such as evidence-based medicine or evidence-based physical therapy (51).

[13] Ibid., 53.

[14] Patricia Briggs, Helen Hawrylack, Ruth Mooney, Donna Papanicolas, and Patricia Taylor, "Engaging Nurses in Clinical Research," *Nursing 2017* 47, no. 2 (February 2017): 14.

of wounded soldiers.[15] As the charge for greater clinical effectiveness in healthcare gained momentum in the early 21st century, evidence-based practice was added to nursing curricula. Evidence-based practice has become a priority in nursing practice as nurses regularly encounter questions, problems, and patient needs that require clinical decision making for the determination of appropriate response.[16]

For those that rely on scientific evidence to guide decision making, it is imperative to recognize levels of evidence; not all evidential reporting has equal standing. Melnyk and Fineout-Overholt offer the following delineation for consideration.[17]

Level I: Evidence from a systematic review of meta-analysis of all relevant randomized controlled trials (RCTs)

Level II: Evidence obtained from well-designed RCTs

Level III: Evidence obtained from well-designed controlled trials without randomization

Level IV: Evidence from well-designed case-control and cohort studies

Level V: Evidence from systematic reviews of descriptive and qualitative studies

Level VI: Evidence from single descriptive or qualitative studies

Level VII: Evidence from the opinion of authorities and/or reports of expert committees

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[15] Longton, 343.

[16] Josefina I. Alejandro, "Lessons Learned Through Nursing Theory," *Nursing 2017* 47, no. 2 (February 2017): 41. Mick, 37.

[17] Bernadette Mazurek Melnyk, and Ellen Fineout-Overholt, *Evidence-Based Practice in Nursing and Healthcare: A Guide to Best Practice.* 3rd ed. (Philadelphia: Wolters Kluwer Health, 2015) reprinted in Autumn Shingler-Nace and Judith Zedreck Gonzalez, "A Pathway to Evidence-based Nursing Management," *Nursing 2017* 47, no.2 (February 2017): 45.

To assist the public and medical providers make informed health care decisions, NCCIH has attempted to ensure that information provided is objective and evidence-based and balances the risks and benefits of complementary and alternative medicine (CAM) interventions. However, the accomplishment of this goal has its challenges. First, massive information about CAM is available to the public, some backed with evidence, other information presented with questionable quality and reliability. Second, the evaluation of the information can be skewed by the lens through which the information is viewed. Evidence-based information can appear to promote a practice, which may actually be unproven or dangerous. Or, in another case, evidence may appear to discredit a practice with proven safety and value.[18]

NCCIH has supported diverse epidemiological studies in the use of CAM studies, and the necessity of continued research with respect to CAM therapies is as important today as it was when Congress established the National Center for Complementary and Alternative Medicine[19] in 1998 with its goal to gather qualified experts to partner in the study of CAM. Practitioners in CAM disciplines possess the knowledge of application of CAM interventions, while biomedical/behavioral sciences experts offer the scientific and technological information of the basic biological, physiological, and clinical effects and safety of CAM.[20] Research questions explored include,[21] but may not be limited to,

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[18] National Center for Complementary and Alternative Medicine, *Exploring the Science of Complementary and Alternative Medicine: Third Strategic Plan 2011-2015* (Washington, DC: US Department of Health and Human Services-National Institutes of Health, February 2011), 54.

[19] The National Center for Complementary and Integrative Health was called the National Center for Complementary and Alternative Medicine at the time of its inception.

[20] National Center for Complementary and Alternative Medicine, 48.

[21] Ibid., 37.

1. The frequency and characteristics of CAM use

2. How and why individuals and health care providers decide whether or not to use CAM therapies

3. The benefits, risks, and cost-effectiveness of CAM use in the general population

4. The potential role of CAM interventions practices, or disciplines in supporting healthy lifestyles and well-being

## Energy Medicine Therapy

Traditionally rooted in Eastern medicine, energy medicine therapy is a subset of complementary medicine therapies. Energy medicine is based in the premise that all things, living and non-living, have an energy field which can be assess and measured.[22] The energy healing technique involves channeling healing energy through the hands of a practitioner into a client's body to restore the normal energy balance.[23] Referred to by the National Center for Complementary and Integrative Health as *biofield*, synonymous terms for the energy include *chi* in traditional Chinese medicine, *prana* in Indian Ayurvedic medicine, *ki* in Japanese.

*Human energy field* (HEF) is the term used to refer to the form of energy in humans, different from electromagnetic radiation that emanates from the human body.

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[22] Susan M. Wright, "Validity of the Human Energy Field Assessment Form," *Western Journal of Nursing Research* 13, no. 5 (1991): 635.

[23] "Terms Related to Complementary and Integrative Health," National Center for Complementary and Integrative Health." https://nccih.nih.gov/health/providers/camterms.htm (accessed March 17, 2017).

Electromagnetic radiation can be measured through conventional diagnostic techniques such as electrocardiograms and electroencephalograms. The theory purports that HEF contains a number of layers, each with differing frequencies. *Chakras* refer to the structures which transform the energy between layers into the physical body. Practitioners believe that illness begins with disturbances in the energy field, and true healing can occur when the HEF is balanced.[24]

Although no one cohesive opinion with respect to objective evidence for HEF is held by supporters, energy medicine therapy is based on the premise that energy permeates the universe. Science has established that activities of cells and tissues generate electrical fields that can be detected on the skin surface. Laws of physics demand that any electrical current creates a magnetic field in the surrounding space. Too small to be detected, biologists had assumed that these fields had no physiological significance.[25] However, research of Russian scientists Semyon and Valentina Kirliam in the 1960's purported to have captured images of life energy emanating from people's hands and from plant leaves.

In 1963, Electrical Engineers, Gerhard Baule and Richard McFee from Sracuse University, detected the biomagnetic field projected from the human heart, and the measurements were later confirmed in 1970 by David Cohen. The sensitivity of the Superconducting Quantum Interference Device (SQUID) magnetometer, the device used to measure biomagnetic field, was improved and allowed the measurement of magnetic

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[24] Dónal O'Mathúna and Walt Larimore, *Alternative Medicine: The Christian Handbook* (Grand Rapids, MI: Zondervan, 2007), 191-192.

[25] Jim Oschman, "Science Measures the Human Energy Filed," *Reiki News Articles.* www.reiki.org/reikinews/sciencemeacures.htm (accessed February 9, 2017).

fields around the head produced by brain activities by 1972. Research has shown that all tissues and organs produce specific magnetic pulsations, known as biomagnetic fields and these recordings can complement traditional electrical records such as the electrocardiogram and electroencephalogram.[26]

The SQUID magnetometer allowed studies of therapeutic touch at the University Of Colorado School Of Medicine by Dr. John Zimmerman in the 1980's. It was determined that huge pulsating biomagnetic field was derived from the hands of the therapeutic touch practitioner. These pulsations were in the same frequency range as brain waves and flowed through the full range of therapeutic frequencies, thus demonstrating that healing may be stimulated in any part of the body. This hypothesis was supported when Japanese colleagues studied practitioners of various martial arts and other healing methods.[27]

The energy field is affected by disease, illness, or pain, and the clinical modality therapeutic touch is the practice of assessing the human energy field with one's hands. Through this assessment, alterations, variations and/or asymmetry in the field are identified. The application of therapeutic touch is an example of a modality used to redirect areas of accumulated energy, reestablish energy flow, and direct energy to depleted areas.[28]

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[26] Ibid.
[27] Ibid.
[28] Wright, 635- 636.

Some supporters of HEF find it to be a faith issue,[29] while some who oppose energy therapy are concerned with the fact that the therapies used in energy medicine cannot be separated from the philosophical and religious beliefs underlying the practices.[30] If that is the case, the spirituality of some may be challenged.

## Mindfulness

Rooted in both eastern and western traditions of religion, philosophy, and psychology, mindfulness is an approach in which one decenters from their thoughts and attends to the present moment.[31] For the practice of nursing, mindfulness may be defined as "A transformative process, where one develops an increasing ability to experience being present with awareness, acceptance, and attention."[32]

Mindfulness may be defined as an attitude of remaining present, watchful, and aware of what is happening without becoming emotionally involved or captured by images or sensations. When one is truly present, there is an absence of either anticipating or ruminating.[33] Mindfulness helps one to identify with being rather than doing.

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[29] O'Mathúna and Larimore, 193.

[30] Ibid., 194.

[31] *Holistic Health Promotion and Complementary Therapies: A Resource for Integrated Practice,* eds. Simon Weavers, Loretta Haught (Gaithersburg, MD: Aspen Publishers, 1999, 2-1:37. Joshua J. Knabb, "Centering Prayer as an Alternative to Mindfulness-Based Cognitive Therapy for Depression Relapse Prevention," *Journal of Religion and Health* 51 (2012): 908.

[32]Beth Fahlberg and Tom Roush, "Mindful Presence: Being 'With' in Our Nursing Care," *Nursing 2016* 46, no. 3 (March 2016): 14.

[33] *Holistic Health Promotion and Complementary Therapies: A Resource for Integrated Practice.* EDS

Preliminary results in research suggest that mindful meditative practices such as breathing methods, guided imagery,[34] and other relaxation practices may be helpful in reducing stress, and may be a technique for depression relapse prevention.[35] These practices may also assist sustaining life changes. For instance, historically, while most weight loss programs focused on diet, little was done to address the impact of stress on food intake and metabolism, and many individuals returned to over-eating. However, recent research suggests that the addition of Yoga or mindfulness medication practices may be associated with greater psychological well-being, less disordered eating, greater weight loss, and improved metabolic function.[36]

Recent mindfulness meditation research suggests that systematic mindfulness training and other meditation practices influence areas of the brain which regulates awareness, attention, and emotion. Analysis of brain-imaging studies suggest that more mindful people may be better able to regulate emotional reactions or have improved self-awareness, while other research suggests that mindfulness trainings is associated with changes in the physical structure of the brain.[37]

Mindful meditation has the focus of what is present without reaction to it or making any judgments on it. This technique is used to learn a more balanced response to the thoughts and emotions of daily life. In general, meditation has been shown to induce changes in the autonomic nervous system which has two components, the sympathetic nervous system and the parasympathetic nervous system. In response to stimuli, the

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[34] "Terms Related to Complementary and Integrative Health."
[35] Knabb, 919.
[36] National Center for Complementary and Alternative Medicine, 45.
[37] Ibid., 22.

sympathetic nervous summons the body to action, whereas the parasympathetic nervous system creates a rest response. Meditation may reduce the sympathetic response and increase the parasympathetic system.[38]

Mindfulness-behavioral cognitive therapy (MBCT) defines mindfulness as "paying attention in a particular way: on purpose, in the present moment, and nonjudgmentally,"[39] and may be used to establish thinking patterns. Due to the fact that mindfulness is often attributed to the Buddhist tradition, some Christians may be uncomfortable with the use of mindfulness. Differences are present, yet a parallel practice may be found in centering prayer, a form of Christian meditation that is rooted in Catholic mysticism, "a method of reducing the obstacles to the gift of contemplative prayer and of facilitation the development of habits conducive to responding to the inspiration of the Spirit."[40] Where MCBT focuses on modes of self-experience other than mental activity, and focus of centering prayer which is the experience of God, many of the MBCT skills are foundational to centering prayer.[41]

## Spiritual and Pastoral Considerations with Associated Norms/Protocols

Terminology and conventional health practices can complicate the understanding of complementary therapies. For example, one study found that the women participants defined complementary medicine broadly, including therapies that differed from

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[38] Brent Bauer, ed., *Mayo Clinic Book of Alternative Medicine, 2nd ed*. (New York: Time, Inc., 2010), 104.

[39] Knabb, 909.

[40] Knabb, 908, 919.

[41] Ibid., 919.

prevailing definitions of CAM in the literature. In other cases, normative health practices seem to have negatively influenced the use of CAM therapies, as individuals described various therapies as "weird," "freaky," and looney."[42]

Some complementary therapies have been placed into *New Age* label, yet *New Age* as a category is not easily defined. *New Age* is not considered to be a single uniform movement, but a network of practitioners whose approach is to think globally but act locally. It is considered to be a syncretistic structure incorporating diverse elements, allowing people to share interests or connections to varying degrees with varying levels of commitment.[43] Confounding the matter is the use of the phrase *New Age* religion. While interest in the *New Age* phenomenon may be a response to people's religious and/or spiritual questions or needs, the core of *New Age* understanding is the time for particular religions is over. To refer to *New Age* as a religion would contradict its self-understanding.[44]

Marketing strategies have added linguistic confusion. Some practices are labeled as *New Age* to promote sales, although the practices are not associated with the *New Age* worldview.[45] For instance, practices associated with *New Age* include but are not limited to acupuncture, biofeedback, chiropractic, kinesiology, homeopathy, iridology, massage, various kinds of "bodywork" (which includes practices such as reflexology, Rolfing, and therapeutic touch), meditation and visualization, nutritional therapies, psychic healing,

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[42] Camille Eckerd Lambo, "Complementary and Alternative Therapy Use in Breast Cancer: Notable Findings," *Journal of Christian Nursing* 30, no. 4 (October-December 2013): 223, 224.

[43] Pontifical Council for Culture and Pontifical Council for Interreligious Dialogue, *Jesus Christ the Bearer of the Water of life: A Christian Reflection on the "New Age,"* p.7, #2. http://www.vatical.va/roman_curia/pontifical_councils/interrelg/documents/rc_pc_)interelg_doc2003020-new-age_en.html (accessed July 29, 2015).

[44] Ibid., p.8, #2.

[45] Ibid., p.27, #4.

herbal medicine, and twelve-step programs.[46] Although these may be clustered together within a *New Age* category, the therapies have varying degrees of scientific evidence and support.

The concern of some, with respect to *New Age* therapies, is participation in a particular therapy may challenge one's spirituality. The current cultural situation leads "many people hover(ing) between certainty and uncertainty these days, particularly in questions relating to their identity."[47] Some find the Christian religion to be patriarchal and authoritarian, others find that political institutions are unable to improve the world, and formal (allopathic) medicine fails to heal people effectively. These perceptions lead many to look inward for meaning and strength and to search for alternative institutions.[48] Additionally, technological advances which include speed of and access to communication has complicated theological discussions. That which is labeled "Christian" or "Catholic" may not actually reflect the teachings of the Catholic Church.[49]

As pointed out in *Jesus Christ the Bearer of the Water of Life: A Christian Reflection of the "New Age,"* the attraction to the *New Age* movement may be influenced by the inattention by Catholic communities to authentic Catholic doctrine and spirituality.[50] Some who oppose *New Age* thought suggest it includes positions the

[46] Ibid., p.11-12, #2,2,3.
[47] Ibid., p.4, #1.1.
[48] Ibid.
[49] Ibid., p.5, #1.2.
[50] Ibid., p.2.

Church has identified as heterodox, more specifically a new way of practicing Gnosticism.[51]

The appeal to this religiosity can be great when the content of Christian faith is weak and individuals seek a more profound spirituality.[52] Unlike the spirituality of Christianity which looks outwards and beyond to God who calls the individual to live the dialogue of love, some versions of *New Age* thought seek to harness the powers of nature and to seek to communicate with another world to discover the fate of individuals, and to help individuals identify how to make the most of themselves and their circumstances.[53]

Another source of spiritual concern is some of the complementary therapies suggest that the source of healing is said to be within oneself, something that can be reached when one is in touch with one's inner energy or cosmic energy.[54] This notion clashes with the concept of Christ as physician and healer. Life and physical health are precious gifts entrusted by God;[55] however, scientific medical or psychological research can contribute to the advancement of health.[56] While the Catholic Church believes it has been charged to "Heal the Sick," the physician of souls and bodies is Christ through his life giving presence.

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[51] Ibid., p.6, #1.4.
[52] Ibid., p.6, #1.5.
[53] Ibid., p.4-5, #1.1.
[54] Ibid., p.12, #2.2.3.
[55] *Catechism of the Catholic Church,* 2nd ed. (Citta del Vaticano: Libreria Editrice Vaticana, 1997), p. 551, #2288.
[56] Ibid., p. 552, #2292.

## Financial Considerations

Complementary medicine therapies can address the ethical obligation of registered nurses by the American Nurses Association to decrease healthcare costs in America. This directive is reiterated by Standard 15 in the *Scope and Standards of Practice for Faith Community Nursing*, "The faith community nurse utilizes appropriate resources to plan and provide nursing services that are safe, effective, and financially responsible."[57]

While cost savings is a good business practice and secular value, Scripture also encourages Christians to be good stewards and not to squander resources.[58] The theme of stewardship, the practice of considering and treating all things, the earth, and one's own life as belonging to God, and oneself as the manager or steward,[59] is seen throughout the Bible. From the creation stories in the book of Genesis (1:28-30, 2:15) where God presented humans with care over the garden,[60] to 1Peter 4:10 which encourages the Christian to use his/her gifts to serve one another as good stewards of God's grace, stewardship is seen as a responsibility to the hearers.

There are many sides to the financial questions resulting from use of complementary medicine therapies. In some cases complementary therapies can be accessed by those with limited financial resources, while in other cases, there are

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[57] *Faith Community Nursing: Scope and Standards*, (Silver Spring, MD: American Nurses Association, 2012), 49.

[58] June Long, "Good Stewardship Means Good Business," Journal *of Christian Nursing* 32, no. 3 (July-September 2015): 189.

[59] *The Catholic Source Book*, (Orlando: Harcourt Religion Publishers, 2007), 95.

[60] Lawrence Boadt, *Reading the Old Testament: An Introduction*, New York: Paulist Press, 1984), 118.

individuals who may desire to avail themselves of a particular therapy, but may not have the resources to access the intervention.[61] Treatment modalities may be less expensive than those found in the conventional medicine model. However, many therapies are not covered by traditional insurance plans, so the expense is borne solely by the individual receiving the treatment. Therapies covered may also require additional medical visits. For instance, massage is not covered by many insurance plans, but can be covered if accessed through chiropractic care. Payment for complementary interventions may burden those who do not have coverage. However, payment for conventional medicine is also an increasing burden as many insurance plans have increased deductibles and co-pays as an attempt to decrease insurance costs, thus an effective complementary therapy treatment may be less expensive.

Vulnerability of an individual may also color the response of an individual regarding their medical treatment options. Those that feel they are "out of other options," or those that have not received relief from conventional medicine, may choose to try complementary medicine therapies, even when the financial liability is of concern.

## Professional Faith Community Nursing and Pastoral Considerations

Faith community nurses have a myriad of influences which contribute to the design of their practice. As a professional, nurses are held to societal demands to maintain a competent knowledge base, provide care consistent with standards, and follow

[61] Lambo, 223-224.

ethical practices. Simultaneously, nurses' actions are framed within the context of the nurses' belief system,[62] and the faith community of the nurse's practice.

## Faith Community Nursing Scope and Standards of Practice

*Faith Community Nurse* is the term used to represent a registered nurse who specializes in faith community nursing.[63] The faith community nurse is obligated to follow the parameters of the professional nurse, as well as those of the faith community within whose location he/she works. Faith community nurses must follow the state practice act under which she/he practices, the American Nurses Association Code of Ethics, and the *Scope and Standards of Faith Community Nursing*.[64]

## Pastoral Considerations

Faith community nurses practice wholistic health which acknowledges heath and illness are human experiences and health may be experienced in the presence of illness or injury. Healing is the process of integrating the body, mind and spirit to create wholeness, health, and a sense of well-being, even when cure is not possible.[65] The differentiating feature between the general practice of the registered nurse and the faith

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[62] Stacy C. Hountras, "What Guides Your Nursing Practice?" *Journal of Christian Nursing,* 32, no. 3 (July-September 2015): 179.

[63] *Faith Community Nursing: Scope and Standards,* 8.

[64] For a complete list of Faith Community Nursing Standards see Appendix A.

[65] *Faith Community Nursing: Scope and Standards,* 8.

community nurse is that the focus of the faith community nurse is the intentional care of the spirit,[66] a realm often associated with ministry.

Although not necessarily within the scope of recognized ordained ministry, faith community nurses do practice within the sphere of pastoral care or Christian ministry. Faith community nursing is a helping profession and therefore bound by the professional and ethical considerations of ministerial practice.

*Ministry as a Profession*

"A basic prerequisite for an ethical ministry is a clear understanding of the minister's calling."[67] However, ministry is more than just an ethical practice of a calling from God, or what may be referred to as vocation. Ministry is also a profession and the title profession connotes particular standards. Although the construct of profession remains a topic of inquiry across a variety of disciplines, and the term is not used in the same way universally, fundamental characteristics of a helping profession include: 1) the nature of the human needs addressed, 2) the vulnerable state of those it serves, 3) the expectations of trust generated, and 4) the social contract implied.[68] Further characteristics which separate a profession from an occupation include 1) extensive training, 2) a significant intellectual component in the training, 3) a trained ability that provides an important service in society, 4) a sense of calling to serve the public,

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[66] Ibid.

[67] Joe E. Trull and James E Carter, *Ministerial Ethics: Moral Foundation for Church Leaders, 2nd Edition* (Grand Rapids, MI: Baker Academic, 2004), 23.

[68] Ibid., 30.

5) autonomy, and 6) self-regulation including a code of ethics.[69] Coalescing the aforementioned qualities, a professional may be defined as, "a broadly educated person with highly developed skills, and knowledge who works autonomously under the discipline of an ethic developed and enforced by peers, who renders a essential and unique social service, and who makes complex judgements, involving potentially dangerous consequences."[70]

Christian ministry exemplifies the general requirements listed above found in a profession. Additionally, the standards of ethical professional Christian ministry practice require 1) appropriate education, 2) competency, 3) autonomy, 4) motivation to serve rather than social status or financial reward, 5) dedication, and 6) an ethical standard of Christian morality.[71] These requirements are illustrated through the practice of faith community nursing.

## Appropriate education

Faith Community Nursing is a specific nursing specialty, first recognized by the American Nurses Association in 1998. Faith community nurses have the minimal credentials of registered nurse, licensed in the state in which he/she practices. The registered nurse must follow the nurse practice act of the state their licensure, and in most states, meet continuing education requirements.

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[69] Ibid.
[70] Ibid., 36.
[71] Ibid., 39-40.

What separates a faith community nurse, from a nurse who works within a faith community, is the additional education of the faith community nurse core curriculum, from an institution credentialed by the Westburg Institute for Faith Community Nursing[72] formerly known as the International Parish Nurse Resource Center. This 40 hour course presents the foundations of the nursing process as it relates to the scope of faith community nursing. While some might say, "a nurse is a nurse, is a nurse," each nursing specialty has its own set of nuances and competencies.

## Competency

Closely related to the education standard is competency. From the functional perspective, the Faith Community Scope and Standards provide the faith community nurse with the expected standards of care. Each standard defines the competencies of care within that standard. However, the faith community nurse must also have enhanced interpersonal skills necessary for a therapeutic relationship between faith community nurse and parishioner to develop. Although, "a nurse, is a nurse, is a nurse," the requirements of interpersonal relationship development may be much different for nurse in a very highly technical position such as surgical nursing, and a faith community nurse working with a client who has just lost their job or someone looking for treatment options related to a particular diagnosis.

[72] The Church Health Center changed the name of the International Parish Nurse Resource Center established in 1986 to the Westberg Institute for Faith Community Nursing in 2016. This name change was intended to reflect the tremendous growth of faith community nursing, and to honor its roots. The change from resource center to institute represented the quality of services and professionalism demonstrated by the organization .

Faith community nurses must possess the knowledge appropriate to the faith community with whom they work. While some faith community nurses may work within their own personal faith tradition, this is not a requirement. Doctrinal issues and pastoral care responsibilities may be tradition or local church specific.

Demonstration of a higher degree of professional competence is encouraged through the developed certification process for faith community nurses. Certification is a process by which a nongovernmental agency validates an individual's knowledge, commitment to professional excellence,[73] professional development and certification recognizes professional standing and experience within a nursing practice. While entry-level nursing education provides foundational knowledge, certification recognizes additional education and validation of clinical expertise and evidence-based practice at a national level.[74] Credentialing demonstrates to the congregation that faith community nursing is not just something done on Sunday mornings at church, but the expertise within faith community nursing is recognized. Credentialing also shows faithfulness as servants of God and efforts to study and learn in order to provide high-quality, wholistic, health ministry.[75]

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[73] Linda A. Briggs, Helen Brown, Karen Kestan, and Janie Heath, "Certification A Benchmark for Critical Care Nursing Excellence," *Critical Care Nurse* 26, no. 6 (December 2006): 47. Linda Laskowski-Jones, "A Framework for Success in Nursing" *Nursing 2017* 47, no. 6 (June 2017): 6.

[74] Sharon T. Hinton, "Nursing in the Church," *Journal of Christian Nursing* 32, no. 3 (July-September, 2015): 145.

[75] Ibid.

Autonomy

Autonomy is a complex, multi-dimensional construct derived from the Greek words *autos* (meaning self) and *nomos* (meaning to rule or hold sway).[76] Autonomy may be present on an individual or group level and can exist within one's personal life, or work environment. While personal autonomy and work autonomy are related to professional autonomy, professional autonomy is rooted in the authority derived from superior competence,[77] and professional nurse autonomy is defined as "belief in the centrality of the client when making responsible discretionary decisions both independently and interdependently, that reflect advocacy for the client."[78]

Professional nurse autonomy is influenced by one's beliefs, life experiences and socialization. Characteristics within professional nurse autonomy and the subset of faith community nursing practice include caring and affiliative relationships with clients, responsible discretionary decision making, collegial interdependence with members of the heath care team, and proactive advocacy for clients.[79] Faith community nurses demonstrate professional autonomy when they function independently and collaboratively as they advocate for clients and are accountable for decisions that they make.

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[76] G. H. Wade, "Professional Nurse Autonomy: Concept Analysis and Application to Nursing Education," *Journal of Advanced Nursing* 30, no. 2 (1999): 311.

[77] Trull and Carter, 31.

[78] Wade, 310, 313.

[79] Ibid., 316.

Motivation to Serve for Other than Social Status and Financial Rewards

"The very heart of nursing is to serve patients, their families, and communities to improve their quality of life and promote wellness,"[80] and the same heart is foundational to the practice of faith community nursing. Nursing integrates care and empathy with knowledge and expertise. Caring, the basis of a therapeutic relationship is critical to the practice of nursing. Caring permits an individual to connect with others, respecting human dignity and responding with compassion.[81]

The term of faith community nursing evolved from the original name, parish nursing, to better describe the scope of faith community nursing. Not all faith community nursing is accomplished within a Christian community; faith community nursing is also practiced in other religious traditions. While the characteristic of a motivation to serve in the name of Christ would be specific to Christian faith traditions, the overarching notion of serving in the name of a greater power is the core of faith community nursing.

This thesis-project is concerned with Christian faith community nursing which is rooted in the healing mission of Jesus Christ. While there are different models of faith community nursing practice, the foundation of the practice remains the spiritual beliefs of the faith community.

The scope of faith community nursing spans four different models of practice, two of which are unpaid models. The first is the unpaid congregational model. In this

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[80] Michele G. Hackney, "Called to Teach: Purpose or Paycheck," *Journal of Christian Nursing* 33, no. 4 (October-December 2016): 251.

[81] Beth Boyd, "Are You Demonstrating the Value of Caring?" *Journal of Christian Nursing* 32, no. 2 (April-June, 2015): 126.

model, the faith community nurse is responsible to the faith community. In the second model, the faith community nurse is also not paid, but is responsible to an institution that places the nurse within a faith community. The third model is the institutional paid model. Again a nurse is placed within a faith community, but is financially supported by an institution. This model is used to assist a faith community starting a faith community nursing program, or it may be done as outreach by an institution to a faith community. In southwest Florida, one faith community nurse is employed by a hospital, to assist a local church with their outreach services such as the hot lunch program and food pantry which bring in local residents. The fourth model is the paid congregational model. The faith community pays and/or provides benefits to the faith community nurse to work within their faith community or through the direction of the faith community.

While it may not be universally true, it is suspected by this author most faith community nurses seek this type of position to serve others. Many faith community nurses receive no monetary compensation as a reward for their service. Therefore, this writer proffers that Christian faith community nurses work within the faith community as a means of contributing to and improving the lives of others by serving in the name of Christ, and in response to the call from God.

## Dedication

Christian nurses have a dedication to nursing as Christ would and many embrace the concept of Kingdom Nursing. In fidelity to God and the client, Kingdom Nursing is

focused, dynamic, patient-centered, inspired by the qualities of Christ, and influenced by the presence of the Holy Spirit in the life of the nurse.[82] Christian faith community nurses extend Jesus' healing mission and profess the Good News of Jesus' salvific work. When appropriate, faith community nurses work to assist an individual achieve healing when cure may not be expected.

Prospective faith community nurses complete a spiritual biography as part of the application process and the presence and work of the Holy Spirit in their lives is often identified. Faith community nurses know that they serve God, who is in control, and they have confidence that the Holy Spirit will provide direction in the aspects of life. Christ-centered care to others is considered to be a personal gift to God,[83] and demonstrated by serving with the heart and hands of Christ promoting healing and wholeness guided by best practices.[84]

## Ethics

Demanded by the Gospel, reinforced by expectations of professionalism which require ethical conduct, ministry requires the minister live under the discipline of an ethic upholding the highest standards of Christian morality in relation to their clients, colleagues, and community.[85] Recognizing the need for professionals to act in an

[82] Nancy A. Eckerd, "Nursing for the Kingdom of God," *Journal of Christian Nursing* 32, no.4 (October-December 2015): 250.
[83] Ibid., 251.
[84] Ibid., 253.
[85] Trull and Carter, 40-41.

appropriate manner, the American Nursing Association articulates the ethical obligations of all registered nurses in the *Code of Ethics for Nurses with Interpretative Statements.*

Ethical practice is further embraced by the practice of faith community nursing as exemplified by Standard 7 of *Faith Community Nursing: Scope and Standards* which states, "The faith community nurse practices ethically."[86] Ethics is a branch of philosophy that involves clarifications of what should or ought to be done by an individual and society, or what is right or wrong. Situated within the broader classification known as biomedical ethics,[87] nursing ethics is a system of principles concerning actions of the nurse in relationship with patients, and is foundational to the practice of nursing and its social contract with society. The American Nurses Association's *Code of Ethics for Nurses with Interpretative Statements,* was developed to provide guidelines for nursing practice, research, and education. The statement provides an articulate statement of the ethical obligations and duties of every individual who enters the nursing profession, provides the profession's nonnegotiable ethical standard, and expresses nursing's self-understanding of its commitment to society.[88]

An overview of the competencies of the faith community nurse with respect to ethical practice reveals the faith community nurse will guide practice following the ANA's *Code of Ethics for Nurses with Interpretive Statements,* preserve and protect the health care consumer's confidentiality and autonomy recognizing the health care consumer as the core member of the health care team, and assists the healthcare

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[86] *Faith Community Nursing: Scope and Standards*, 35.

[87] Jean Bokinskie, "Ethical Issues," in *Foundations of Faith Community Nursing* (Memphis, TN: International Parish Nurse Resource Center, 2014), 4.

[88] Ibid., 9-10.

consumer in self-determination and informed decision making. The standard challenges the faith community nurse to contribute to resolving ethical issues concerning the healthcare consumer, takes necessary action when illegal or inappropriate behaviors jeopardize the best interests of the health care consumer, and advocates for equitable health care consumer care. Finally, competencies of the ethical standard includes the incorporation of ethical and moral theories, principles, and models in planning care, and acknowledge and respects the tenets of the faith and spiritual belief system of the health care consumer.[89]

Values, which are standards or qualities of a person or a social group, play a key role is the discipline of making ethical decisions. The practice of a faith community nurse is influenced by the values of multiple entities. The faith community nurse must hold to the religious values of the religious institution under which the faith community nurse is employed. He/she must hold to the professional values articulated by the American Nurses Association *Code of Ethics*, and the state professional practice act under which the faith community nurse is licensed. The faith community nurse must also be faithful to his/her personal values. An ethical issue arises when a dispute between two or more moral values conflict with each other. Ethical analysis for decision making must be employed.

[89] *Faith Community Nursing: Scope and Standards*, 36.

Although religious beliefs are one source of values, values are also derived from one's culture, family, peer group, and work group. Values are generally prioritized by an individual and values guide one's choices.[90]

Religious values are a product of the history and culture from which they have emerged. Often deeply embedded in the experience of a person, religious values impact choices about life with a view to please God, and command or teach beyond doing what is good for the sake of doing good.[91]

Professional values are standards upheld by a particular professional group. Codes of ethics which are developed by professional organizations often list the basic values of the professional group and the principles that protect these values.[92]

Personal values are those important to the individual. Often unconsciously influencing our choices, judgements or actions, personal values are often an aggregate of cultural, religious, and professional values.[93]

Moral decision making is some cases may seem easy; however determination of the right actions in specific cases may seem less clear. An ethical dilemma, a situation where there are at least two equally justifiable courses of action or judgements but a person is uncertain which one to pursue or choose, occur within healthcare settings. The intricacy of ethical decisions continues to increase as developments are made in technology, and influences in economics, law, and secular values intersect in the health

[90] Bokinskie, 5.
[91] Ibid., 6.
[92] Ibid.
[93] Ibid.

care composite. For instance, value confliction make the answer as to the moment at which life begins or when life sustaining treatments should be terminated difficult. The protection of values may make the determination as to when an individual should no longer live alone difficult. Justice and equality issues may affect who is served in a particular venue.[94]

Multiple ethical theories, or the principles which guide what should be done in a situation, further complicates the decision making process. For instance, utilitarianism states that decisions should be based on what is the greatest good for the greatest number of people. Deontology maintains that decisions are based on moral obligations. Virtue or character ethics is based on the notion that actions are aimed at some good. The ethics of caring involves relationship, connections, and mutuality. These concepts are consistent with the practice of nursing and the specialty of faith community nursing.[95]

Ethical principles which provide sound moral reasons for judgement or action must be considered. For instance, beneficence directs persons to help others in need,[96] and is the obligation to do good, and prevent harm to the individual. The obligation to avoid harm is the goal of nonmaleficence. Justice is the principle which guides how benefits and burdens should be fairly distributed among patients. Autonomy, based on dignity and respect of an individual, respects the individual's right to determine their own choices, although it may be limited if choices affect the rights of another. Veracity is the obligation to be truthful. The responsibility to be faithful to one's commitments is

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[94] Ibid., 6-7.

[95] Bokinskie, 7.

[96] Albert R. Jonsen, Mark Siegler, and William J. Winslade, *Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine, 8th edition* (New York: McGraw Hill, 2015): 111.

demonstrated in the principle of fidelity. Confidentiality prevents disclosure of private information shared within the client-nurse relationship without permission. And, the sanctity of human life is the obligation to view human life as sacred.[97]

In addition to the aforementioned standards of ethical professional Christian ministry practice, the practice of faith community nursing places the good of the individual paramount; advocacy a central nursing ethic.[98] Advocacy includes action to safeguard individuals when their care is endangered, to avoid paternalism. Advocacy also requires an assessment for adequate and appropriate health care resources, initiating referrals when appropriate.[99]

For many years, physicians professed the Hippocratic Oath attributed to Hippocrates, commonly recognized as the father of medicine. Hippocrates was revered for his ethical standards in medical practice. Although approximately 60 medical writings have survived which bear his name, it is suspected that they were not written by him.[100]

A modification of the Hippocratic Oath was composed in 1893 by Lystra Gretta and a Committee for the Ferrand Training School of Nurses in Detroit Michigan. Named for the individual thought to embody the ideals of nursing, "The Nightingale Pledge" guides nurses in their practice. The following is often pledged by graduate nurses:

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[97] Bokinskie, 8-9.
[98] Ibid., 10.
[99] Ibid.
[100] "Hippocrates," *Britannica Online Encyclopedia.* http://www.britannica.com/print/topic/266627 (accessed March 27, 2013).

> "I solemnly pledge myself before God and in the presence of this assembly to pass my life in purity and to practice my profession faithfully I will abstain from whatever is deleterious and mischievous, and will not take or knowingly administer any harmful drug. I will do all in my power to maintain and elevate the standard of my profession, and will hold in confidence all personal matters committed to my keeping and all family affairs coming to my knowledge in the practice of my calling. With loyalty will I endeavor to aid the physician in his work, and devote myself to the welfare of those committed to my care."[101]

## Theological Discernment Resources

Assisting a client in making health care decisions, which includes the participation in complementary medicine therapies, requires the synthesis of both nursing and ministerial considerations on the part of the Faith Community Nurse. When a clear decision is not available, Christian ministry requires all means available are used to discover the right thing to do.[102] This section will explore resources available for the discernment process by the faith community nurse which includes ethical theories supporting practice, and Roman Catholic statements and guidelines.

### *Ethical Theories Supporting Practice*

The gospel of John 16:13 declares, "… the Spirit of truth, he will guide you to all truth."[103] But how will the truth be recognized? The role of the Holy Spirit helps the individual to know what God asks, as well as the recognition of good and bad spirits.

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[101] Bokinskie, 9.
[102] Trull and Carter, 46.
[103] Donald Senior, ed. *The Catholic Study Bible: New American Bible* (New York: Oxford University Press, 1990), 175.

While many roles of the spirit are acknowledged, the relationship to prophecy and knowing God's will connects the individual to knowing how God wants the individual to act.[104]

Some look to the Bible as the ultimate "formative and normative authority for moral decision making." While the primary source for doing ethics may be the Bible, it is not as easy as just following the Bible. A particular action which is condoned in one instance in the Bible seems to be condemned in another. The Bible simply does not provide clear answers for all ethical dilemmas.[105]

Christians can look to the treasury of tradition.[106] Church ancestors such as Augustine, Aquinas, Ignatius of Antioch, Catherine of Sienna, Luther, Calvin and others have offered insights to Christian living accessible for ethical decision making activities. Reflection on Christian life continues and writers of the modern era have enriched our understanding of ethical decision making. For instance, the documents of the Second Vatican Council have influenced the understanding of the People of God and how the Church should connect with the world and Pope Francis has challenged the perception of the principles of judgement and mercy.

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[104] Charles E. Curran, *The Catholic Moral Tradition Today: A Synthesis* (Washington, DC: Georgetown University Press, 1999), 177.

[105] Trull and Carter, 45.

[106] Ibid., 46.

*Conscience: Formation and the Primacy of Conscience*

"Conscience is generally understood as a judgment about the morality of an act to be done or omitted or already done or omitted by the person."[107] Although value ethics of Christian principles and norms and social ethics of justice contribute to moral decision making, they can change over time and cannot cover every situation; therefore, conscience is more than just a collection of principles and norms. Defined by the *Catechism of the Catholic Church*, conscience is "the interior voice of a human being, within whose heart the inner law of God is inscribed,"[108] and moves a person to do good and avoid evil at the appropriate time.[109] The conscience, which includes the perception of the moral principles, enables one to assume responsibility for acts performed.[110]

Although the specific terminology has varied through the Catholic moral tradition, it has been recognized human acts require consideration of both the subject/agent of the act, and the reality of the objective situation.[111] Based on the relationship to the subject, an act may be deemed either sincere (right) or insincere. With respect to the objective reality of the situation, a conscience may be understood to be true or erroneous.[112] Synthesizing these constructs leads to the possibility that a conscience may be sincere and true, sincere and erroneous, insincere and true, and insincere and erroneous in a given situation.

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[107] Curran, 172.
[108] *Catechism of the Catholic Church*, 872.
[109] Ibid., 438, #1777-1778.
[110] Ibid., 439, #1780-1781.
[111] Curran, 172-73.
[112] Ibid., 173.

The ideal conscience is one that is both sincere and true. However, while sincere, a conscience may be erroneous based on the available information at the time of the action. Ignorance may be either vincible or invincible. Invincible ignorance is that ignorance for which one cannot have knowledge. However, vincible ignorance occurs when knowledge is available and not accessed by the agent.[113]

For those who wish to act according to one's conscience, a dilemma hovers. That is, while one must follow one's conscience, recognition exists that a conscience may be wrong. Following the primacy of the subjective aspect of conscience does not negate the objective aspect. However, the subjective aspect of conscience, a sincere conscience whether it true or erroneous, has had some priority through Catholic moral tradition. From the writings of Thomas Aquinas it has been understood that one must always obey the certain judgment of his/her conscience, and to act against one's conscience is to condemn oneself.[114] In the 18th century, Alphonsus Liguori expounded an act of a sincere but invincible erroneous conscience is "not only not wrong, it is also good and even meritorious."[115]

The Catholic tradition maintains conscience is essential to making any moral decision.[116] Additionally, an individual has the right to act in conscience and in freedom when making moral decisions.[117] However, to apply one's conscience to a moral decision, it must be informed in accord with human reason and Church teachings, and

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[113] Ibid.
[114] *Catechism of the Catholic Church*, #1789, #1790..
[115] Curran, 174.
[116] Chris Korzen and Alexia Kelley, *A Nation for All* (San Francisco: Jossey-Bass, 2008), 79.
[117] *Catechism of the Catholic Church*, 439, #1782.

moral judgment must be enlightened. Informing and enlightening are serious and lifelong tasks to which all must avail themselves.[118]

Conscience formation involves both the individual person and the institutional Church. Catholics have the moral responsibility to hear, receive, and act upon the Church's teaching.[119] The elements involved with informing the conscience are; 1) the desire to embrace goodness and truth through studying Scripture, the teachings of the Church and the *Catechism of the Catholic Church*; 2) study of the facts and background information of various choices; and 3) prayerful reflection to discern the will of God.[120]

The *Catechism of the Catholic Church* expresses some rules apply in every case of choice consistent with conscience. First, one may never do evil so that good may result from it. Next, the Golden Rule should be applied, "Whatever you wish that men (women) would do to you, do so to them." Finally, charity always proceeds by way of respect for one's neighbor and his (her) conscience. Should one sin against another wounding their conscience, then one sins against Christ. An individual may not do anything that causes another to misstep.[121]

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[118] Ibid., 440, #1783-1784, 1798.

[119] United States Conference of Catholic Bishops, *Forming Consciences for Faithful Citizenship*, 2, #63.

[120] Ibid., 7, #18.

[121] *Catechism of the Catholic Church*, #1789, #1789.

*Virtue in Moral Decision Making*

If one sees morality solely as behavior guided by rules, one may see actions as something outside themselves, having a reality of their own. However, actions are also an expression of person. The moral goodness of a person is the quality of a person which is cultivated not just in actions, but through developing certain attitudes, virtues, and outlooks. Focusing too heavily on results may detract from the call to be a loving person in the intimation of Christ.[122] Morality concerns more than the ethics of doing, it also concerns the ethics of being.

Character refers to the kind of person who acts in a particular way. Focusing on the motives, intentions, attitudes, and dispositions of the inner self, character is a better reflection of the moral life of an individual than isolated actions.[123] Character itself is not directly viewed; rather the fruits of character are displayed through action. Personality traits that make up one's character have traditionally been called virtues.[124]

Virtue may be defined as habitual and firm disposition to do good, allowing an individual to not only perform good acts, but to give the best of his/herself, and allows an individual to pursue good. St. Gregory of Nyssa described the goal of a virtuous life is to become like God.[125]

Human virtues are the firm attitudes, stable dispositions, habitual perfections of intellect and will that govern our passions, in accordance with reason and faith. They are

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[122] Richard M. Gula, *Reason Informed by Faith* (New York: Paulist Press, 1989), 7.
[123] Ibid., 30.
[124] Trull and Carter, 49.
[125] *Catechism of the Catholic Church*, #1803.

acquired through education, deliberate acts, and perseverance. Human effort is required to develop moral virtues, the fruit and seed of morally good acts.[126]

Historically, justice, temperance, courage, and prudence have been considered to be the cardinal virtues. Justice centers on fairness, honesty, and the rule of law. Temperance is the virtue of self-discipline, or the ability to control one's impulses for immediate gratification that may actually be harmful in the long run. Courage, also known as fortitude is the capacity to do what is right or necessary, even when risk may be involved.[127] Prudence is the virtue associated with practical reason which leads to good decision making; prudence is not the same as intelligence. For theologian Thomas Aquinas, the virtue of prudence is the cardinal virtue as prudence affects all other virtues. Aquinas viewed prudence as the right reason of things to be done, developed through practice in deliberation and action.[128]

While the constellation of the virtues contributes to who we are and the way we act, which includes decision making, prudence may be particularly useful to the pastoral minister who is discerning a particular action with another individual. "Prudence is the virtue that disposes practical reason to discern our true good in every circumstance and to choose the right means of achieving it…."[129] The virtue of prudence guides the judgment of conscience and the application of moral principles to a particular situation.

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[126] Ibid., #1804, #1810.
[127] Trull and Carter, 49.
[128] Curran, 180.
[129] *Catechism of the Catholic Church*, 444, #1806.

*Roman Catholic Guidelines/Statements*

As previously cited, following one's conscience is the mandate of the Christian, but this requires that the conscience be properly formed. The formation of conscience is the responsibility of both the institutional Church and the individual. The individual is to embrace the study of Scripture and teachings of the Church and the Church is to provide teachings to its community. This section will explore teachings to provide guidance for the Roman Catholic Faith Community Nurse.

*Dominum et vivificantem*

In 1986, Pope John Paul II promulgated *Dominum et vivificantem*, an encyclical whose subject matter is the Holy Spirit, the center of Christian faith.[130] From the formulation of the Nicene-Constantinopolitan Creed, the Church has professed the Holy Spirit to be "the Lord giver of life," which "has spoken through the Prophets," communicating God's self to human beings.[131]

The Gospel of John describes that as Jesus prepared to leave the world, he told the Apostles of "another Counsellor," also referred to as Paraclete which means counselor, intercessor, or advocate. On the day of Pentecost, although already working in the world, the Holy Spirit was sent to sanctify the Church so that believers might have access to the

[130] Joannes Paulus II, *Dominum et vivificantem*, #2. http://www.newadvent.org/library/docs_jp02dv.htm (accessed February 10, 2015).

[131] Ibid., #1.

Father through Christ in one Spirit.[132] The Holy Spirit was to follow Jesus to continue the work of the Good News of salvation proclaimed by Jesus, through the Church. The Holy Spirit would continue to inspire the spreading of the Gospel, and would help people to understand the correct meaning of the content of Christ's message; the Holy Spirit would ensure continuity and identity of understanding in the midst of changing conditions and circumstance,[133] and the Holy Spirit would guide into the truth, the truth of Jesus' actions and teaching.[134]

*Dominum et vivificantem* reminds the reader, the one definitive source of the moral order is God the creator, the human cannot decide by one's-self what is good and evil. However, the Holy Spirit gives the gift of conscience, and in this conscience the image of Wisdom and Eternal Law may be reflected, the sources of the moral order in man and the world.[135] God in creation revealed himself as omnipotence, which is love. At the same time, God revealed that the human is as the image and likeness of the Creator, called to participate in truth and love.[136] Sin may be seen as disobedience, a transgression of a prohibition laid down by God.[137]

Citing the teaching on conscience when the Second Vatican Council spoke on the vocation and dignity of the human person, *Dominum et vivificantem* clarified that the conscience determines this dignity. The conscience is"the most secret core and sanctuary

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[132] Ibid., #25.
[133] Ibid., #3-4.
[134] Ibid., #6.
[135] Ibid., #36.
[136] Ibid., #37.
[137] Ibid., #36.

of a man, where he is alone with God whose voice echoes in his depths."[138] Conscience is not an independent and exclusive capacity to decide what is good and what is evil, conscience is the "voice of God."[139]

*Redemptoris missio*

*Redemptoris missio,* On the permanent validity of the Church's missionary mandate, was promulgated by Pope John Paul II March 25, 1987. Ultimately this encyclical invited the Church to renew her missionary commitment and an interior renewal of faith and Christian life,[140] as the Church's fundamental function is to direct man's (and woman's) gaze toward the mystery of Christ.[141] This missive also offered guidance with respect to one's responsibility to seek and proclaim truth, as well as to sources of truth.

In this encyclical, Pope John Paul II reminded the faithful of the teaching of the Second Vatican Council. Quoting *Dignitatis humanae,* Declaration on Religious Freedom, the importance of acting in concert with one's conscience was supported. *Dignitatis humanae* stated no one should be forced to act against one's conscience in religious matters.[142]

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[138] Ibid., 43.
[139] Ibid.
[140] Joannes Paulus II, *Redemptoris missio*, #2. http://w2vatican.va/content/jphn-paul-ii/en/encyclicals/documents/hf_ip-ii_enc_07121990_redemptoris_missio.html (accessed July27, 2015).
[141] Ibid., #4.
[142] Ibid., #8.

This document reiterated the mandate of *Dignitatis humanae* that an individual needs to seek truth. "While respecting the beliefs and sensitivities of all, we must first clearly affirm our faith in Christ, the one Savior of mankind…."[143] The missive stated "in accordance with their dignity as persons, equipped with reason and free will and endowed with personal responsibility, all are impelled by their own nature and are bound by a moral obligation to seek truth, about all religious truth. They are further bound to hold to the truth once it is known and to regulate their whole lives by its demands."[144]

Healing and forgiving are two foci of the mission of Jesus one earth, showing great compassion to those suffering distress.[145] Jesus charges people to learn to love, forgive, and serve one another and specifically, people are to "Love one another; even as I have loved you" (Jn 13:34).[146]

*Redemptoris missio* reminds the reader of the activity of the Holy Spirit and the place of inter-religious dialogue in the quest for what is holy and true. While the Holy Spirit is seen as manifested in a special way in the Church, it is recognized that the presence and activity of the Holy Spirit is universal, limited by neither space nor time, and working in the heart of every person as well as societies, cultures, and religions.[147] Through inter-religious dialogue, the Church acknowledges the Spirit "who blows where

[143] Ibid., #11.
[144] Ibid,, #8.
[145] Ibid.,, #14.
[146] Ibid., #15.
[147] Ibid., #28.

he wills,"[148] and the responsibility to find the truth which enlightens all within individuals and other religious traditions.[149]

*Letter to the Bishops of the Catholic Church on Some Aspects of Christian Meditation*

In response to queries regarding meditation and prayer, the Congregation for the Doctrine of Faith penned *Letter to the Bishops of the Catholic Church on Some Aspects of Christian Meditation,* published October 15, 1989. With increased interactions between Christians and other religions, many had questioned if there was value for Christians in non-Christian forms of meditation.[150] Defining Christian prayer as "a personal, intimate and profound dialogue between man and God,"[151] and noting that prayer is both personal and communitarian, this reply critiqued the relationship between Christian and non-Christian prayer.

The *Letter to the Bishops of the Catholic Church on Some Aspects of Christian Meditation* directed the individual to Scripture, both the Old Testament and New Testament, for guidance on how one should pray.[152] The letter also acknowledged the work done by the Second Vatican Council to develop the theological and spiritual understanding of Christian prayer in the Dogmatic Constitution of the Second Vatican

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[148] Ibid., #55.
[149] Ibid., #56.
[150] Congregation for the Doctrine of Faith, *Letter to the Bishops of the Catholic Church on Some Aspects of Christian Meditation,* #2. http://www.ewtn.com/library/curia/cdfmed.htm (accessed January 22, 2015).
[151] Ibid., #3.
[152] Ibid., #4.

Council.[153] However, in spite of the leadership of the Church, this communiqué warned from the early centuries of the Church, incorrect forms of prayer had crept into use.

Although there may be differences between Christian and non-Christian prayer, the missive presented something cannot be rejected purely on the fact that its roots are non-Christian. The letter stated, "…the Catholic Church rejects nothing of what is true and holy in these religions,"[154] nor should ways (of prayer) be rejected out of hand just because they are not Christian. In fact, "one can take from them what is useful so long as the Christian conception of prayer, its logic and requirements are never obscured."[155] While there may be similarities between non-Christian and Christian methods of prayer, one must be careful to never obfuscate the aim of Christian prayer.

Influences from non-Christian religions were considered in this letter. For instance, the increased consciousness of the relationship between one's bodily posture and its effect on prayer, was addressed. For example the "Jesus Prayer" which adapts itself to the natural rhythm of breathing can be of help to many people. However, the letter went on to caution that the use of symbolism can become itself an idol and therefore an obstacle to communication with God.[156]

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[153] Ibid., #6. .

[154] Ibid., #16.

[155] Congregation for the Doctrine of Faith, *Letter to the Bishops of the Catholic Church on Some Aspects of Christian Meditation*, #16. http://www.ewtn.com/library/curia/cdfmed.htm (accessed January 22, 2015).

[156] Ibid., #27.

*Jesus the Bearer of the Water of Life: A Christian Reflection on the New Age*

The success and popularity of the *New Age* movement challenged the Church. Many who explore *New Age* thought have a genuine yearning for a deeper spirituality, something that will touch their hearts, and a way of making sense of the world.[157] These yearnings cannot be ignored, but problems are found in the alternative answers to life's questions purported through *New Age* practice. *Jesus the Bearer of the Water of Life: A Christian Reflection on the New Age* proposes that Catholics need to root themselves firmly in the fundamentals of faith, have an understanding of authentic Catholic doctrine and spirituality, and recognize the longings found in the hearts of some individuals. The ultimate movement for the Christian should be towards a closer relationship with Jesus, the Church's one foundation and the heart of every Christian action and every Christian message.[158]

Recognizing the inability to claim that everything associated with the *New Age* movement is good, or that all aspects are bad, members from the Pontifical Councils for Culture and for Interreligious Dialogue, the Congregation for the Evangelization of Peoples and the Pontifical Council for Promoting Christian Unity produced *Jesus the Bearer of the Water of Life: A Christian Reflection on the New Age* in 2003, prepared to guide Catholics who are responsible for preaching the Gospel and teaching the faith.[159] Responding to the fact that the phenomenon of *New Age* was influencing many aspects of

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[157] Pontifical Council for Culture and Pontifical Council for Interreligious Dialogue, *Jesus Christ the Bearer of the Water of life: A Christian Reflection on the "New Age,"* p.6, #1.5. http://www.vatical.va/roman_curia/pontifical_councils/interrelg/documents/rc_pc_)interelg_doc2003020-new-age_en.html (accessed July 29, 2015).

[158] Ibid., p. 7, #1.5, p.32, #5.6.

[159] Ibid., *p*. 3,#1.

contemporary culture, the goal of the effort was to provide an aide to explain how the *New Age* movement differed from the Christian faith.

The committee acknowledged the document did not provide answers to all the questions raised by the *New Age* movement. The reflection was intended to highlight areas where the *New Age* spirituality contrasts with the Catholic faith as well as to refute positions espoused by *New Age* thinkers in opposition to Christian faith.[160] Aided by a solid grounding in one's faith, the paper offers a tool to help Catholics understand the principles behind *New Age* thinking to critique elements encountered from a Christian perspective and to enable dialogue with others.[161]

*Jesus the Bearer of the Water of Life: A Christian Reflection on the New Age* concludes that the gnostic nature of the *New Age* movement requires it to be judged in its entirety. From the Christian perspective, one cannot accept some aspects of the *New Age* religiosity while rejecting others.[162] To aide assessment, a comparison between the *New Age* understanding and the Christian perspective on the following topics was offered:[163]

1. Is God a being with whom we have a relationship or something to be used or a force to be harnessed?

2. Is there just one Jesus Christ, or are there thousands of Christs?

3. The human being: is there one universal being or are there many individuals?

4. Do we save ourselves or is salvation a free gift from God?

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[160] Ibid.
[161] Ibid., p.8, #2, p.3, #1.
[162] Ibid., p.27, #4.
[163] Ibid., p.27-31, #4.

5. Do we invent truth or do we embrace it?

6. Prayer and medication: are we talking to ourselves or to God?

7. Are we tempted to deny sin or do we accept that there is such a thing?

8. Are we encouragedto reject or accept suffering and death?

9. Is social commitment something shirked or positively sought after?

10. Is our future in the stars or do we help to construct it?

Ultimately, "The relationship of the person, group, practice, or commodity to the central tenets of Christianity is what counts."[164] "The Church's one foundation is Jesus Christ, her Lord. HE is at the heart of every Christian action, and every Christian message."[165]

*Guidelines for Evaluating Reiki as an Alternative Therapy*

The United States Conference of Catholic Bishops Committee on Doctrine addressed the question, "What is the Church's position on various alternative therapies," in *Guidelines for Evaluating Reiki as an Alternative Therapy.* This document declares that Catholic Church recognizes healing through both divine grace, and healing that utilizes the power of nature.[166]

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[164] Ibid., p.35, #6.2.
[165] Ibid., p.32, #5.
[166] United States Conference of Catholic Bishops, Committee on Doctrine. Guidelines *for Evaluating Reiki as an Alternative Therapy*. Washington DC: United States Conference of Catholic Bishops, March 25, 2009, #2.

Divine grace is reflected in the ministry of Christ and later through his disciples commissioned to continue his work of physical healings. The Church has continued intercession on behalf of the sick through the invocation of the name of the Lord Jesus, asking for healing through the power of the Holy Spirit in the forms of sacramental laying on of hands and anointing with oil and/or prayers for healing, sometimes asking for the aid of the saints.[167]

*Guidelines Evaluation Reiki as an Alternative Therapy* does not limit the methods of healing to divine healing. Natural means of healing have been supported by the Church through its history of caring for the sick, reflected by heath care entities sponsored by the Church. The possibility of healing by divine power does not necessarily negate the use of natural means of healing that are available. The power of healing is not at human disposal, and therefore, the options to use natural means of healing that are at human disposal is appropriate, and should not be neglected.[168]

With respect Reiki specifically, the document clarifies that the understanding of neither the mechanism of Reiki nor its efficacy has the backing of the scientific community, and therefore, the justification for Reiki rests in other than science. While some practitioners identify Reiki with the divine healing known to Christians, the Bishops teach this is a mistaken notion. For Christians, access to divine healing is by prayer to Christ as Lord and Savior. Adding a prayer to Christ in the Reiki therapy does not negate the essence of Reiki.[169] The Bishops deemed that Reiki therapy was

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[167] Ibid.
[168] Ibid., #3.
[169] Ibid., #7-8.

inappropriate for Catholic institutions. "A Catholic who puts his or her trust in Reiki would be operating in the realm of superstition, the no-man's-land that is neither faith nor science."[170]

*Amoris laetitia*

Returning to the teaching of Thomas Aquinas, the Post Synodal Apostolic Exhortation *Amoris laetitia*, penned by Pope Francis, reminds the faithful of the need for discernment in decision making. Although this missive addressed the subject of family and the Church, many of the principles espoused may be transferred to other situations.

Pope Francis reiterated the need to incorporate a developed and enlightened individual conscience into the Church's praxis. While conscience not only recognizes situations which do not follow the demands of the Gospel, conscience can also recognize with sincerity and honesty the most generous response to be given to God in complex situations.[171] While general rules set forth a good which can never be disregarded or neglected, their formulation cannot provide absolutely, nor can practical discernment in a particular situation rise to the level of a rule.[172] Citing scripture, Francis reminds the reader that fraternal charity is the first law of Christians,[173] which should be the goal in discernment in challenging situations.

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[170] Ibid., #11-12.
[171] Francis, *Amoris Laetiti,* Vatican City: Libreria Editrice Vaticana, 2016), p. 234, #303.
[172] Ibid.,, p. 234 #304.
[173] Ibid., p. 234, #306.

## Evidence Based and Spiritual Considerations

The development of complementary therapies as an adjunct to conventional medical treatment has required medical professionals to understand such therapies and their potential use. For instance when establishing a plan of care, a practitioner may find it useful to know relaxation, decreased perception of pain, reduced anxiety, and improved sense of well-being have been shown to enhance quality of life, in situations where curative treatment is not possible.[174]

At the same time, medical practitioners, particularly those working within a faith community must be aware so as not to create scandal for an individual. Therapies and remedies should only be used if there is benefit, as evaluated by scientific data, and the physical component can be separated from the underlying belief system. For Christians, freedom of choice is but one consideration, one must also understand how one's actions may be interpreted.[175] The apostle Paul admonishes the Corinthians that leading another in an incorrect action is "sinning against Christ."[176]

Understanding that an individual is a complex organism comprised of his/her bio-psycho-spiritual features necessitate that these same features be considered in helping to formulate treatment plans. The following section will present and overview of the scientific evidence for the complementary medicine therapies of this thesis discussion, as well as the spiritual aspects which may be of concern.

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[174] Barbara Burden, Sandy Herron-Marx, and Collette, "The Increasing Use of Reiki as a Complementary Therapy in Specialist Palliative Care," *International Journal of Palliative Nursing,* 11, no. 5 (2005), 248.

[175] O'Mathúna and Larimore, 72.

[176] Senior, 262 .

## Acupuncture

Estimates suggest that millions of Americans use acupuncture, annually, [177] which is defined by The National Center for Complementary and Integrative Health as a "family of procedures involving stimulation of anatomical points on the body by a variety of techniques."[178] American practitioners of acupuncture incorporate traditions from other countries such as China and other Asian countries where it has practices for thousands of years as a key component of traditional Chinese medicine.

Traditional Chinese medicine embraces the notion that the body has two opposing and inseparable forces yin and yang. Health is achieved when the forces are balanced, and disease occurs when there is a blockage in the flow of qi. Qi is the vital energy or life force thought to regulate spiritual, emotional, mental, and physical health. Acupuncture is intended to relieve blockages to reestablish and maintain health.

Scientific inquiry continues to explore the possible mechanism of the pain-relieving effects associated with acupuncture which remains unclear to the Western understanding of medicine.[179] Theories include the idea that needles release endorphins which regulate pain perception, alteration of the brain chemistry which cause a release of various neurotransmitters, the counter irritant theory in which pain in one area of the

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[177] "Acupuncture." https://www.fdl.wi.gov/cofuploads/acupuncture.pdf (accessed March 17, 2017).

[178] "Terms Related to Complementary and Integrative Health."

[179] "Acupuncture."

body is reduced when another area is irritated, regulation of the nervous system, stimulation of the immune system, and pain relief is a result of a placebo effect.[180]

The value of acupuncture is debated; one position claims benefit from the practice while the other position asserts that acupuncture presents the placebo effect. Studies suggest that acupuncture can help manage certain pain conditions such as chronic low-back pain, neck pain, dental pain, and osteoarthritis/knee pain. Acupuncture may also help reduce the frequency of tension headaches and prevent migraine headaches. Acupuncture was found to reduce nausea and vomiting after chemotherapy or surgery. Acupuncture was not found to be effective in acute back pain, controlling asthma, reducing weight, or smoking cessation. The value to other health conditions is unclear.[181] Most frequently scientifically studied are the acupuncture techniques which involve the penetration of skin with thin, solid, metallic needs that are manipulated by hands or electrical stimulation.

Guidelines for the recommendation of acupuncture are inconsistent. However, while acupuncture is not without potential side effects when performed with unsterile needles or with improper therapy delivery, it is generally considered to be a safe modality when performed by an experienced, well trained practitioner, and with the use of sterile

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[180] O'Mathúna and Larimore, 129-130. Gabriel Tan, Michael H. Craine, Matthew J. Bair, M. Kay Garcia, James Giordano, Mark P. Jensen, Shelley M. McDonald, David Patterson, Richard Sherman, Wright Williams, and Jennies C. I Tsao, "Efficacy of Selected Complementary and Alternative Medicine Interventions for Chronic Pain," *Journal of Rehabilitation Research and Development* 44, no. 2 (November 2, 2007), 214-215.

[181] "Acupuncture: In Depth." https://nccih.nig.gov/health/acupuncture/introduction.htm (accessed March 17, 2017). "Acupuncture." O'Mathúna and Larimore, 130. Tan et al., 208 found acupuncture may be beneficial as adjunct for pain relief for those that are at risk for adverse effects to pharmacological interventions, probably effective for treating low back pain and possibly beneficial for treating premenstrual syndrome.

needles.[182] Acupuncture tends to be a low cost therapy, however, it should not be used in lieu of conventional medicine treatment, and diagnosis of disease should not be performed by an acupuncturist who does not have conventional medical training. Additionally the practitioner should be vetted, and training, experience and credentials checked.

Spiritually, acupuncture can be alarming to some. The use of the needles to manipulate life energy can resemble a spiritual practice. Practitioners who observe the traditional Chinese medicine precepts and religion may expose and attempt to influence patients to follow Eastern worldview. Others may summon spiritual powers to assist treatments, exposing people to occult influences.[183]

## Biofeedback

Biofeedback is an intervention which teaches individuals how to control bodily functions such as breathing, heart rate, blood pressure, muscle tension, and skin temperature through the use of simple electronic devices.[184] Considered by some to be training verses therapy, this mind-body technique assists the modification of physiology

[182]"Acupuncture: In Depth."
[183] O'Mathúna and Larimore, 72.
[184]"Terms Related to Complementary and Integrative Health." "Biofeedback" University of Maryland Medical Center. http://umm.edu/medical/altmed/treatment/biofeedback (accessed April 1, 2017).

for the purpose of improving physical, mental, emotional, and spiritual health through active participation in training and regular practice by the client.[185]

Through biofeedback training, clients learn to control physiological responses which were once thought to be involuntary. Physiological signals are translated into visual or auditory cues which can be perceived by the participant through a device such as a computer monitor. With the assistance of a trained practitioner, this feedback allows individuals develop control over physiological responses.[186]

The mechanism of action of biofeedback in pain management has not been firmly established, however, many who benefit from biofeedback have conditions which are triggered or exacerbated by stress.[187] Relaxation techniques, which include biofeedback, can be helpful in managing the body's natural response.

For some pain conditions evidence suggests that pain modulation with biofeedback is achieved via decatastrophizing and learning lowered arousal techniques that prevent the maintenance of sympathetic pathways to trigger points. For other conditions, pain may be countered through decreasing sympathetic overload, parasympathetic withdrawal and stress hormones. For other conditions, pain may be affected through changing improper muscle contraction, and blood flow patterns.[188]

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[185]Dana L. Frank, Lamees Khorshid, Jerome F. Kiffer, Christine S. Moravec, and Michael G. McKee, "Biofeedback in Medicine: Who, When, Why and How?" *Mental Health In Family Medicine* 7, no. 2 (June 2010): 85-86.

[186] Ibid., 85.

[187]"Biofeedback"

[188] Tan et al., 214.

Biofeedback is gaining acceptance with the American public, and it is making its way into the realm of conventional medicine. Research has demonstrated biofeedback to be successful intervention for treating a variety of medical conditions.[189] Using the Association for Applied Psychophysiology and Biofeedback and the Society for Neuronal Regulation's published criteria for evaluating clinical efficacy of biofeedback, determination of efficacy follows. Biofeedback has been found to be efficacious and specific for urinary incontinence in females. It has been found to be efficacious in anxiety, attention deficit disorder, adult headache, hypertension, temporomandibular disorders, and urinary incontinence in males. Biofeedback has been found to be probably efficacious for alcoholism and substance abuse, arthritis, chronic pain, epilepsy, fecal elimination disorders, headache (pediatric migraine), insomnia, traumatic brain disorder, vulvar vestibulitis.[190] Research continues to investigate potential benefits for asthma, Raynaud's disease, nausea and vomiting related to chemotherapy, epilepsy, and tinnitus.[191]

Biofeedback is widely used and considered to be a safe intervention; no negative side effects have been reported. However, consumers with serious mental health issues are advised to discuss the appropriateness of this therapy.[192]

Biofeedback does not require the alteration of consciousness. It does not require the acceptance of a particular belief.[193]

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[189] Frank, 86, 88. "Biofeedback."

[190] C. Yucha and C. Gilbert, *Evidence-based Practice in Biofeedback and Neurofeedback.* Wheat Ridge, CO: Association for Applied Psychophysiology and Biofeedback, 2004. Printed in Michael G. McKee, "Biofeedback: An Overview in the Context of Heart-Brain Medicine," *Cleveland Clinic Journal of Medicine* 75, no. 2 (March 2008): 833-834.

[191] Bauer, 98.

[192] "Biofeedback"

## Hand Mediated Energetic Healing Practice

Healing touch and therapeutic touch are examples of hand-mediated energetic healing practices (HMEH) found within the practice of nursing. HMEH is based on the idea that the hands of practitioners transmit "energy forces" that improve the energy flow which runs through the body of the recipient. Practitioners assert that through their hand movement they are able to locate and remove energy force disturbances.[194]

To assess the energy condition of the recipient, the practitioner begins with his/her hands a few inches above the body. The practitioner then touches various energy points on the body in a manner designed to move energy from the practitioner to the recipient. This technique is thought to strengthen and reorient the energy flow within the recipient.[195]

This complementary therapy practice (HMEH) draws on the ancient healing practices of many cultures which include the Indian culture, Asian culture, and the American Indian culture. Touch therapy may be combined with religious beliefs and practices, however therapeutic touch differs from "laying on of the hands," in that it does not require professed faith or belief by the practitioner or patient.[196]

The theory supporting HMEH is that pain and other symptoms occurs when energy is imbalanced,[197] the goal therapeutic touch is to restore harmony and balance in

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[193] O'Mathúna and Larimore, 141.
[194] Bauer., 117.
[195] Ibid., 124.
[196] *Holistic Health Promotion and Complementary Therapies: A Resource for Integrated Practice*, 2-8:4.
[197] Tan et al., 213.

the energy system to promote self-healing.[198] It relies on the practitioner's ability to interpret the receiver's energy flow and select appropriate intervention and protocols.[199]

The effects of HMEH are attributed to energy for the following reasons. First, energy is the closest image to what practitioners and recipients describe as feeling during the session. Second, the results attributed to HMEH cannot be the result of physiologic responses to physical touch.[200] The foundation of energetic healing and HMEH is the understanding that the human body has an electromagnetic field (aura). This field can be experienced when a person outside the visual field quietly enters a room on the presence if felt by another. The body also has an electric current that flows along parallel pathways (meridians) and information analyzing structures (chakras). One's body uses the energy and one's consciousness gives meaning to the information.[201]

HMEH is a practice which has been taught in nursing curriculum and has been used by nurses in a variety of practice arenas such as hospitals, nursing homes, home health care, and hospice care. Reports reflect that HMEH has been used to elicit relaxation, help lower blood pressure, reduce edema, temperature, hives, pain, anxiety, premenstrual syndrome, fatigue, depression, diarrhea, and headache. It has also been used during chemotherapy and following radiation therapy. Reportedly it has promoted healing and boosted the immune system. However, research methodologies and findings are inconsistent. While many report feeling better after a session, it is not clear whether it

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[198] *Holistic Health Promotion and Complementary Therapies: A Resource for Integrated Practice.* 2-8:7.

[199] Ibid., 2-8:1.

[200] Ibid.

[201] Ibid., 2-8:2,7.

is based on the therapy or the placebo response based on time, care, and attention spent by the practitioner.[202]

This therapy gained popularity at a time when health care practitioners were seeking ways to show greater compassion. Although often thought to be an innocent, loving, compassionate therapy that allowed more contact with individuals, spiritual concerns may arise in spite of the fact that practitioners assert that the religious connotations of the practice have been removed. For instance, HMEH may be mistakenly associated with laying on of the hands found in the Bible, although hands need never touch the body. The theory of HMEH is that there is manipulation of nonphysical human energies and practitioners access their inner spirits to receive guidance for the healing session. If human life does not exist, telling people that one is passing energy through them may produce the nocebo effect.[203] Additionally, non-supporters suggest that HMEH is so intermeshed with energy manipulation that these modalities should not be used by any Christian.[204]

## Prayer

Prayer offers a challenge to research and establishing evidence on which to base practice. This challenge is reflected in the absence of prayer in the 2007 National Health Interview Survey by NCCAM as "prayer" is widely used in multiple ways of diverse

[202] Ibid., 2-8:2. O'Mathúna and Larimore, 261-262. Tanet al., Michael H. 201 noted one study which found therapeutic touch to be superior to placebo for reduction of tension-type headache pain, however, insufficient evidence was found to use therapeutic touch for chronic pain. Further study to include larger sample size for review was recommended.

[203] O'Mathúna and Larimore, 28-29, 260.

[204] Ibid., 195, 262.

spiritualties and cannot be specifically measured, which may falsely inflate reported CAM use.[205] Nonetheless, studies have found that respondents pray for their health and of those who prayed, a majority believed prayer improved their health.[206]

Empirical studies have not produced conclusive results on the efficacy of prayer on health.[207] Reasons proffered for these results include the notions it is beyond human research capability to prove God's response to prayers, and/or it is inappropriate to "test" God. Others believe, while recognizing methodology limitations of prayer research, scientific design can reliably examine potential health benefits of prayer.[208]

The fact that the benefits of prayer have not been scientifically proven has not led to the dismissal of prayer as an intervention. For instance, although research on intercessory payer to alleviate illness has not shown consistent or clear effects of intercessory prayer, reviewers suggested that no changes be made in the provision of payer for the sick.

Although measurement of effectiveness of prayer has been critiqued, the public believes there are positive health benefits of prayer.[209] For instance, prayer was mostly directed toward wellness yet prayer was also associated with illnesses characterized by

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[205] YeounSoo Kim-Godwin, "Prayer in Clinical Practice: What Does Evidence Support?" *Journal of Christian Nursing* 30, no. 4 (October-December 2013): 210.

[206] Ibid. Kim-Goodwin cited Koenig, King, and Carson's (2012) conclusion that based on an exhaustive review of research that "people of all faiths and walks of life use prayer in life, health, and illness with positive outcomes." Anne M. McCaffrey, David Eisenberg, Anna T. R. Legedza, Roger Davis, and Russell S. Phillips, "Prayer for Health Concerns: Results of a National Survey on Prevalence and Patterns of Use," *Achieves of Internal Medicine* 164 (April 26, 2004): 858, 860 reported that nationals surveys suggest that many Americans believe in the healing power of prayer, and one-third of US adults surveyed used prayer for health concerns.

[207] McCaffrey et al., 858. O'Mathúna and Larimore, 112.

[208] Kim-Godwin, 210.

[209] Ibid.

pain and/or aggravating symptoms, non-specific diagnosis, and those with limited treatment options. In those surveyed, a majority used prayer with conventional medicine practices, and generally reported high levels of perceived helpfulness.[210]

Pharmacological intervention solely or combined with psychotherapy is used for treatment of depression, yet these interventions do not provide relief for all patients. Although efficacy of the intervention cannot be determined, nor was the specific form of prayer identified, an analysis of the use of prayer from 2002-2007 established that prayer may be used in some demographic groups as an alternative or complementary form of therapy for depression. Additionally, spiritually is used as an active coping strategy with individuals with mental health issues. The researchers suggest that prayer remains a common coping strategy for some individuals when dealing with health concerns and should be taken into account in the consideration of treatment options and individual coping resources.[211]

Although often considered to be the most popular complementary medicine therapy used in the United States, some find difficulty with the reference of prayer as a therapy.[212] The Christian biblical understanding of prayer is specific, that is communicating with God in humility, as per Gods will, and in the name of Jesus. The term therapy is often understood to include the expectation of a quid pro quo. If one does

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[210] McCaffrey et al., 861. This study did not illicit the ways in which prayer was perceived as helpful.

[211] Amy B. Wachholtz and Usha Sambamthoori, "National Trends in Prayer Use as a Coping Mechanism for Depressing: Changes from 2002 to 2007," *Journal of Religion and Health* 52 (2013): 1366-67.

[212] O'Mathúna and Larimore, 236. O'Mathúna and Larimore cite three Harvard Medical School surveys which demonstrate that in 1990, 25.2 % of the respondents, in 1997 35.1% of the respondents, and in 2002 45.2% respondents used prayer. In 2002 the CDC survey showed that 43% prayed for their own health, 24.3% had others pray for their health, and 9.6% participated in a prayer group.

something, then there will be a benefit. While prayer can produce benefits, it is not understood to be a cause and effect relationship, the focus of prayer is God's will. God's answer for the encounter may be "yes," "no," or "wait."[213]

## Reflexology

Comparable to the therapeutic manipulations found in Egypt, India, and China, reflexology was developed in 1915 by William Fitzgerald. This modality is based on "zone theory" which speculates specific areas on the soles of the feet correspond to other parts of the body, and pressure applied to areas affects organs and the health of the individual Foot charts are used by reflexologists to guide foot massage and pressure application to mitigate a problem elsewhere in the body. Within the scope of reflexology, pressure may also be applied to points on the hands and ears. [214]

This manipulation intervention may be performed by massage therapists, chiropractors and physical therapists. Devices such as rubber balls, rubber bands, and wooded sticks may be used to assist the work of the practitioner. There seems to be little evidence to support that reflexology can treat symptoms and or disease processes, although proponents claim it may treat asthma, diabetes, and cancer.[215] However, reflexology may be an effective way to reduce stress, it may be beneficial for palliative care for cancer patients, and studies by the National Cancer Institute and the National

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[213] Ibid., 236-237, 242.

[214] Bauer, 136. O'Mathúna and Larimore, 50. Brent A. Bauer, "What is Reflexology? Can it Relieve Stress?" https://mayoclinic.org/healthy-lifestyle/consumer-health/expert-answers/what-is-reflexology/faq-20058139 (accessed October 24, 2017).

[215] Bauer, 136.

Institutes of Health show this complementary therapy may reduce pain and psychological symptoms such as anxiety, depression, and enhance relaxation and sleep.

Reflexology appears to have little risk and is considered to be safe. However, robust pressure may be uncomfortable for some recipients of the therapy.[216] Practitioners have also reported stimulating a "healing crisis" associated with "detoxification" which may elicit light-headedness, disturbed sleep, and diarrhea.[217]

Reflexologists may interpret their work in terms of life energy manipulation. This interpretation offer similar concerns as those found with other therapies on the energy medicine spectrum for some Christians.

## Reiki

*Reiki* is a Japanese term which means "universal life energy," "universally guided" or "spiritual energy,"[218] and as an intervention, Reiki is defined by the Reiki Regulatory Working Group as a method of natural healing. The ability to heal oneself and others is passed on through initiation or attunement.[219] Once taught to practitioners in secret, Reiki is now openly promoted, and even offered in some hospitals and through health care agencies.[220]

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[216] Ibid.

[217] O'Mathúna and Larimore, 251.

[218] Barbara Burden, Sandy Herron-Marx, and Collette Clifford, "The Increasing Use of Reiki as a Complementary Therapy in Specialist Palliative Care," *International Journal of Palliative Nursing*, 11, no. 5 (2005), 250. Tan et al., 201.

[219] Burden, Herron-Marx, and Clifford, 250.

[220] O'Mathúna and Larimore, 253-254.

The concept of "energy" in relation to the biologic system is not well defined, and its interpretation differs depending on the educational and experiential background of the interpreter.[221] While conventional medicine views energy as emanating from the physical body with no therapeutic value itself, for complementary medicine practitioners, the concept is less well defined. For the many practitioners, energy is believed to be an integral part of the functioning of the physical, emotional, psychological, and spiritual being. The energy exists in and radiates from the physical body. Traditional eastern healthcare practitioners believe that illness or disease results from an obstruction to the body's natural flow of energy and the role of the therapist is to release the blockage.[222]

The mechanism of energy healing is not understood, and this thesis-project is not intended to provide detained accounts of postulated theories. One theory suggests the mechanism is that of the Gate theory which proposes that pressure receptors are longer and more myelinated than pain fibers, therefore, pressure signals are transmitted faster and close the gate to pain signals.[223] Other theories advanced are based on the hypothesis that energy medicine involves the transfer of bioinformation carried by a small energy signal which effects a change in the health state of the recipient.[224] These proposals require a shift from the Newtonian mechanistic view of the human body which espouses that all physical reactions are believed to be the result of purely physical causes. Instead, the prevalent theories of energy healing engage an understanding closer to that of Einstein's Theory of Relativity which promotes the idea of a fourth dimension of time,

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[221] Burden, Herron-Marx, and Clifford, 248-249.
[222] Ibid., 249.
[223] Tan et al., 213..
[224] Burden, Herron-Marx, and Clifford, 249.

space, and gravity in which mass and energy are different manifestation of the same thing, and mass and energy are interchangeable. Therefore, people can be considered complex bundles of frozen energy, and the human body, at least at the atomic level, is composed of different kinds of vibrating energy.[225]

The notion of energy medicine also includes the concept of intentionality. Intentionality may be described as the idea that the healer holds a benevolent desire for the patient to achieve or sustain a health state. Intentionality further assumes the effects of the healer's intention will enable a positive change in the patient. Intentionality is a concept that is not unique to complementary intervention philosophy; it is also found in nursing literature which acknowledges the intentionality and transpersonal aspects of nursing as a caring phenomenon.[226] For instance, nursing theorist Jean Watson proposes caring as the essence of nursing and connotes responsiveness between the nurse and the person; a co-participation between the individuals.[227] Watson describes the facets of intentionality and consciousness as a framework for transpersonal nursing which embraces the notion of a dynamic energetic spirit manifesting aspects of being and becoming in the caring moment. According to Watson, intentional transpersonal practice is mindful and reflective, "graced with beauty and loving attention to our own and others' humanity."[228] For Watson, the foundational concepts of a transpersonal caring and healing nursing model are intentionality and consciousness.[229]

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[225] Ibid.

[226] Ibid., 249-250.

[227]"Jean Watson, Caring Science as Sacred Science," Theoretical *Foundations of Nursing*, 1. http://nursingtheories.weebly.com/jean-watson-html (accessed February 18, 2016).

[228] Jean Watson, "Intentionality and Acting-Healing Consciousness: A Practice of Transpersonal Nursing," *Holistic Nursing Practice,* 16, no. 4 (2002), 12-13. Watson explains *noetic* sciences seek to

Martha Rogers, a nursing theorist, views the human being as an energy field;[230] a patient is regarded as a "unitary human being" who must be viewed as a whole as patients cannot be divided into parts.[231] Rogers purports "the irreducible nature of individuals as energy fields, different from the sum of their parts and integral with their respective environmental fields, differentiates nursing from other sciences and identifies nursing's focus."[232]

The patient exists within and coexists with the environment, making the patient and the environment one. Health, which is on a continuum with illness, is an expression of life process of the patient which is characterized by energy field, openness, pattern, and pan dimensionality. Nursing is based on "knowledge-based consciousness in a goal-directed relationship with the client,"[233] the understanding and caring for human beings

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enhance conventional science by exploring aspects of reality such as mind, consciousness, and spirit which can encompass intentionality, aspects included in yet transcending physical phenomena. Related to *noetic* views are *transpersonal* perspectives as they share interest in the theoretical concepts of intentionality and consciousness. *Transpersonal* refers to values of deep connectedness, or relationship, and subjective meaning, and shared humanity. The transpersonal caring theory makes intentionality, a focused caring-healing consciousness, more explicit. "…one's intentionality becomes activated through one's consciousness focus toward aspects of reality that incorporate, but transcend the physical as the object of attention."

[229] Ibid., 13-14.

[230] Susan Kun Leddy, "Energy: A Conceptual Model of Unitary Nursing Science," *Visions: The Journal of Rogerian Nursing Sciences*, 12, no.1 (2004), 17.

[231] "Martha Rogers Nursing Theorist," *Nursing Theory*, 1. http://nursing-theory.org/nursing-theorisis/Martha-E-Rogers.php. Accessed February 18, 2016. According to Rogers, the energy field is a fundamental unit for all living and unliving which has the characteristic of openness, that is, energy fields are open and extend into infinity. The concept of openness provides a way to view and the patient and the associated environment as a whole, exchanging energies which are continuously changing in intensity, density, and extent. For and overview of this nursing theory see "Martha Rogers: The Science of Unitary and Irreducible Human Beings, *Theoretical Foundations of Nursing*, 1-3. http://nursingtheories.weebly.com/martha-rogers.html or *Visions: The Journal of Rogerian Nursing Sciences*, 12, no.1 (2004).

[232] Barbara Byrne Notte, Carol Fazzini, and Ruth A. Mooney, "Reiki's effect on patients with total knee arthroplasty: A Pilot Study," *Nursing 2016* 46, no 2 (February 2016): 18.

[233] Leddy, 20.

in wholeness and mutuality of the person-environment,[234] "the science of irreducible human and environmental energy fields arrived at by a synthesis of facts and ideas."[235] The facts emanate from the science of nursing which is the knowledge specific to the field of nursing extending from scientific research. The ideas are found in the art of nursing, which is the creative use of the scientific research to improve the life of the patient. Therapeutic touch, humor, music, meditation, and guided imagery are noninvasive modalities for this nursing model.[236]

Reiki treatment is holistic, neither symptom nor pathology specific, therefore treatment duration varies. While often reported that Reiki can do no harm,[237] statements exist which warn practitioners are to carefully assess those with diabetes, pacemakers. Although there is no documented evidence to substantiate the following warnings, some discourage the treatment of those with psychiatric disorders or subject to seizures as these conditions may be exacerbated.[238]

Little high quality research has been done on the intervention of Reiki, and Reiki has not been shown to be useful for any health-related purpose according to the National Center for Complementary and Integrative Health.[239] Anecdotal evidence suggests that reiki alleviates anxiety, stress, perception of pain, and promotes a feeling of wellbeing

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[234] Martha Raile Alligood and Jacqueline Fawcett, "Interpretive Study of Martha Rogers' Conception of Pattern," *Visions: The Journal of Rogerian Nursing Sciences*, 12, no.1 (2004):, 8.

[235] Sonya R. Hardin, "Editorial: Pattern of the Field," *Visions: The Journal of Rogerian Nursing Sciences*, 12, no.1 (2004), 6.

[236] "Martha Rogers Nursing Theorist."

[237] "Reiki: What you Need to Know." https://nccih.nih.gov/health/reiki/introduction.htm. (Accessed April 29, 2015)

[238] Burden, Herron-Marx, and Clifford, 250.

[239] "Reiki: What you Need to Know." https://nccih.nih.gov/health/reiki/introduction.htm. (accessed April 29, 2015). Tan et al., 201 concluded little evidence from controlled trials was available to support the use of Reiki for pain.

through it profound relaxation effects. One study demonstrated the ability to increase hemoglobin and hematocrit levels. A study investigating the effects of Reiki on relaxation and stress showed both biological and physiological changes supported the relaxation response.[240] A recent study published in *Nursing 2016* presented a pilot study of Reiki's effect on patients with total knee arthroplasty. This limited study found that Reiki may be an effective component in the management of surgical patient's postoperative pain, and the success of the study contributed to the ability of Reiki availability to patients undergoing orthopedic surgery, patients with pain management and palliative care consults, other patients referred to the Reiki service.[241]

Reiki is based on the notion that energy is not guided by the mind, but by a higher power, and in this context, the construct of a higher power holds no religious belief. The higher power refers to the spiritual dimension of whatever or whoever is believed to represent a superior being.[242] Confusion may arise with the definition of the word "healing" as some may understand this word to mean a cure, thus false hopes may be raised.

Although training by a Reiki master is required, Reiki training is easily accomplished, and requires no formal academic prerequisites. Training involves learning to open oneself to the energy so that it may flow freely through the practitioner.[243] While the model of preparation can be a benefit for those interested in training, the lack of practitioner standards may cause concern for the health care consumer.

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[240] Burden, SandyHerron-Marx, and Clifford, 251.

[241] Notte, Fazzini, and Mooney, "Reiki's effect on patients with total knee arthroplasty: A Pilot Study," *Nursing 2016* 46, no 2 (February 2016): 17,22.

[242] Burden, Herron-Marx, and Clifford, 250.

[243] O'Mathúna and Larimore, 253.

Access to Reiki is made easier than some other complementary therapies in the fact that a physician referral is not required for Reiki intervention. While offering a sense of empowerment and control, the decision puts the onus of finding a qualified practitioner on the individual.

Reiki may offer benefits. First of all, Reiki is non-invasive, non-pharmacological, and may be provided in most settings. Therefore, there is no concern regarding pharmacological interactions, nor potential for risk which may accompany invasive procedures. Health state, gender, age, religion, and cultural beliefs are not determinants for reiki therapy.[244]

Reiki practitioners explain to the recipient that all levels of human experience are touched, body, mind, and emotions prior to treatment. Practitioners place their hands lightly on or just above the receiver's body. The length of treatment varies from twenty minutes to one hour. Reiki can be performed with the recipient fully clothed and either seated in a chair or in a reclining position.[245]

Reiki may benefit the quality of life of an individual. As previously mentioned, anecdotal reports claim that relaxation, decreased perception of pain, stress alleviation, and promotion of a feeling of well-being are results of reiki intervention.[246] The relaxation achieved through Reiki may also serve to augment other medical treatments. Because of the interaction between the practitioner and client, the client's sense of receiving care may also be enhanced.

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[244] Burden, Herron-Marx, and Clifford, 252.
[245] Notte, Fazzini, and Mooney, "18.
[246] Burden, Herron-Marx, and Clifford, 252.

Reiki has its sceptics, both from the medical profession and from pastoral representatives. Those who ascribe to the philosophy of Western medicine, seek clear evidence for the practice of Reiki and this evidence is not yet available. Described as a "healing system," the mechanism of healing during treatment or within the context of the recipient's life is not clear.[247] Reiki is based on the belief that energy exists which supports the body's innate or natural healing abilities, however, scientific evidence does not yet support the existence of such energy.[248]

Some religious leaders assert that Christians should have nothing to do with Reiki suggesting that the practice is spiritually unsafe. Some spiritual leaders find Reiki to be in opposition to biblical Christianity, uncomfortable with claims that Reiki is an opportunity to Christians to live out one's call to heal. In some cases, proponents of Reiki may have experienced benefits from receiving and practicing Reiki. Others claim that it is a legitimate way to exercise the gift of healing. Others claim that the life energy is the Holy Spirit.[249]

Embedded in training attunements and healing sessions is communication with spirits which is denounced in both the New Testament and Old Testament as sorcery, mediumship, and spiritism. Some suggest that Reiki should not be accessed as spirit interaction can be perilous to an individual affecting the spiritual, emotional, and/or physical health.[250]

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[247] Ibid., 252-253.
[248]"Reiki: What you Need to Know."
[249] O'Mathúna and Larimore, 254.
[250] Ibid., 255.

Through *Guidelines for Evaluation Reiki as an Alternative Therapy*, the Committee of Doctrine of the United States Conference of Catholic Bishops delivered the conclusion that promotion, support, or use of Reiki therapy is inappropriate for Catholic institutions, or those representing the Church as Reiki. Reiki is not compatible with Christian teaching or scientific evidence.[251] To utilize a therapy not supported by scientific evidence is not prudent, and to put one's trust in Reiki would be subjecting oneself to the realm of superstition which has the potential to corrupt one's worship of God.[252]

## Tai chi

Tai chi is a mind body practice which originated in China as a martial art and a means of self-defense. Often dubbed "moving meditation," participants in Tai chi exercise move their bodies slowly and gently conscience of their breathing. The slow, relaxed, graceful movements create routines known as forms, and each movement flows into the next posture without pause.[253] This practice is increasing in the United States as an exercise program and as a supplement to other health care modalities.

A variety of factors contribute to the popularity of this modality. First of all, Tai chi is generally safe for people of all ages and fitness ability. The low impact nature of

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[251] United States Conference of Catholic Bishops, Committee on Doctrine. Guidelines *for Evaluating Reiki as an Alternative Therapy*. Washington DC: United States Conference of Catholic Bishops, March 25, 2009, #12.

[252] Ibid., #10, #11.

[253] "Terms Related to Complementary and Integrative Health," "Tai Chi: An Introduction. https://nccih.nih.gov/health/taichi/introduction.htm (accessed April 29, 2015). Many postures are thought to have been created through the observation of animal and bird movements. O'Mathúna and Larimore, 258.

this exercise reduces the impact to muscles and joints. It does not require special equipment. Finally, Tai chi may be practiced individually or as a group, each model creating its own benefits.[254]

The leading cause of injury for those 65 years of age and older, fatal and non-fatal, is falls. Every fourteen seconds, an older adult is seen in an emergency department for an injury related to a fall.[255] 300,000 individuals are hospitalized yearly for hip fractures, and studies that 95% of the fractures are caused by falls.[256] Studies show that an important fall prevention strategy is physical activity with balance, strength, training, and flexibility components. Research has demonstrated, and The Centers for Disease Control and Prevention, National Center for Injury Prevention and Control cite tai chi as an example of exercise with can increase one's balance and flexibility.[257] Tai chi appears to reduce fall risk not only physically, but also cognitively. Through regular practice, Tai

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[254] Bauer, 114.

[255] "Falls Prevention." www.area10agency.org/fallsprevention (accessed April 18, 2017). According to the Florida Health Department statistics for the catchment areas of the faith community nurses interviewed for this thesis project, Lee County has a fall death rate of 13.6 per 100,000 and Collier County has a fall death rate of 13.9 per 100,000 for the years 2013-2015. http://www.flhealthcharts.com/charts/injuryAndViolence/Default.aspx (accessed April 19, 2017).

[256] "Hip Fractures Among Older Adults." www.cdc.gov/homeandrecreationalsafety/falls/adulthipfx/html (accessed April 18, 2017)

[257] "Falls Prevention." "What You Can Do To Prevent Falls." www.cdc.gov/stedi/what_you_can_do_brochure-a.pdf (accessed April 18, 2017). Bauer, 114. "Tai Chi: What the Science Says." https://nccih.nih.gov/health/providers/dugest/taichi-science. (accessed April 14, 2017) Fuzhong Li, Peter Harmer, K. John Fisher, and Edward Mcauley, "Tai Chi: Improving Functional Balance and Predicting Subsequent Falls in Older Persons," *Medicine & Science in Sports & Exercise* 36, no. 12 (2004): 2051 concludes tai chi training improves functional balance which is predictive of subsequent reduction in fall frequency in personals aged 70 and older at least for about six months. The report suggests consideration of tai chi for fall prevention programs for older persons, as a balance-retraining program, and as part of a multifaceted treatment for fall prevention. O'Mathúna and Larimore, 259.

chi seems to impact one's confidence in not falling, mitigating the fear of falling which is a fall risk factor.[258]

Bone mineral density is one measure of bone strength. Low bone mineral density is associated with osteoporosis, a bone disease which is a risk factor for fractures. One important strategy in the prevention of osteoporosis is to strengthen bone through exercise. A systematic review of research published in the *Archives of Physical Medicine and Rehabilitation* (2007) found Tai chi may be an effective, safe, and practical way to maintain bone mineral density in postmenopausal women.[259]

A Tuffs Medical Center study, partially funded by the National Center for Complementary and Integrative Health, found Tai chi was as helpful as physical therapy in reducing pain and improving physical functioning. 204 patients, age 40 and older, were randomly assigned to either a Tai chi training group for twelve weeks or a standard one-on-one physical therapy session twice a week for six weeks followed by a home based exercise program for six weeks. Participants were then encouraged to maintain their program for a total of fifty-two weeks. At the terminal assessment, both groups had similar decrease in pain and improvement. A strong point of this research was the fact

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[258] Paul Lam, Pamela Kircher, Maureen Miller "Tai Chi For Fall Prevention," https://www.cdph.ca/gov/programs/NEOPB?Documents/Taichiforcallprevention (accessed April 18, 2017). The 2013 Cochrane review cited in "Tai Chi: What the Science Says." https://nccih.nih.gov/health/providers/dugest/taichi-science. (accessed April 14, 2017) found that tai chi significantly reduced risk falling.

[259] "Tai Chi May Help Maintain Bone Mineral Density in Postmenopausal Women." https://nccih.nih.gov/research/results/spotlight/081407.htm (accessed April 10, 2017).

that the participants were typical of patients with knee osteoarthritis, some obese, and some older, yet all able to participate in the assigned programs.[260]

The constellation of symptoms of Parkinson's disease includes movement disorders. A randomized controlled trial conducted in 2012 of 195 patients with Parkinson's disease demonstrated that participation in tai chi improved balance better than resistance training or stretching in patients with mild to moderate Parkinson's disease. The follow-up analysis conducted in 2014 found that patient reported outcome associated with tai chi showed a greater probability of continued exercise behavior than either clinical outcomes or patient-reported outcomes from resistance training or stretching.[261]

A group of researchers published a study in the *New England Journal of Medicine* supporting Tai chi as a potential adjunct for those with fibromyalgia, a condition which is characterized by muscle pain and fatigue to maintain muscle strength, flexibility, and overall fitness. A 2010 study of 66 participants compared an attention control group that received wellness education and practiced stretching exercises to a group who received tai chi group that received instruction in tai chi principles and techniques and practiced ten forms of Yang-style Tai chi. After twelve weeks, the Tai chi group had a significantly greater decrease in total score on the Fibromyalgia Impact Questionnaire,

[260] "Study Shows Tai Chi and Physical Therapy were Equally Helpful for Knee Osteoarthritis." https://nccih.nih.gov/research/results/spotlight/tai-chi-knee-osteoarthritis_2016 (accessed April 10, 2017).

[261] "Tai Chi: What the Science Says."

and reported higher self-reported scores on daily activities such as walking, shopping, and housecleaning. The improvements continued to be present at twenty-four weeks.[262]

Tai chi may offer psychological support. Further research is necessary; however in combination with other therapies, tai chi may help to treat depression and anxiety. The previously mentioned Tuffs Medical Center study found that while both groups had decreased pain and improvement in physical functioning, patients in the Tai chi group also had greater improvement in the symptoms of depression and realized an increase in the quality of life.[263]

Cognitive function may be modestly enhanced in older adults without cognitive impairment with Ttai chi participation. The review of twenty studies involving 2553 participants age 60 and older, with and without cognitive impairment, found beneficial effects in health adults who practices tai chi as compared with nonintervention and exercise controls. A second systematic review of nine studies including 632 healthy adults concluded that there were potential beneficial effects on cognitive ability in healthy adults as compared with usual physical activities. [264]

Limited evidence shows Tai chi may improve sleep quality in older adults.[265] Sedatives are often prescribed for individuals with sleep disorders, yet there is a potential for negative side effects. Interventions such as cognitive behavioral interventions are not

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[262]"Tai Chi May Benefit Patients With Fibromyalgia." https://nccih.nih.gov/research/results/spotlight/081810.htm (accessed April 10, 2017). "Tai Chi: What the Science Says." also reported a 2012 randomized controlled of 101 participants which suggested that combing tai chi movements with mindfulness improved fibromyalgia symptoms and functional mobility.

[263]"Study Shows Tai Chi and Physical Therapy were Equally Helpful for Knee Osteoarthritis."

[264] "Tai Chi: What the Science Says."

[265] Ibid. A 2011 systematic review of 20 studies involving eight complementary therapy techniques found evidentiary support for tai chi in the treatment of chronic insomnia.

always possible. In a study conducted by researchers at the University of California, Los Angeles, it was determined that participants in Tai chi chih sessions (the Westernized version of tai chi), experienced a slightly greater improvement in self-reported sleep quality than those who participated in health education classes.[266] Tai chi participants in the aforementioned study regarding fibromyalgia also experienced improved sleep quality.[267]

Tai chi may impact cardiac health such as lowering cholesterol levels, improve symptoms of congestive heart failure, improve aerobic capacity, and Tai chi can help with stress reduction.[268] The most common primary care diagnosis in the United States is hypertension, commonly known as high blood pressure. In spite of pharmacological advances, many patients continue to experience inadequate blood pressure control. Yet, benefits of lowering blood pressure include decreased risk of stroke, myocardial infarction, heart failure, and cardiovascular-related death. A comprehensive systematic review of Chinese and English language on the effects of tai chi on blood pressure revealed tai chi may have a positive effect on blood pressure, and may be as effective as

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[266] "Tai Chi Chih Improves Sleep Quality in Older Adults." https://nccih.nih.gov/research/results/spotlight/011109.htm (accessed April 10, 2017).

[267] "Tai Chi May Benefit Patients With Fibromyalgia.

[268] Bauer, 114. "Tai Chi: What the Science Says" found limited, inconsistent evidence available on the effectiveness of tai chi for cardiovascular health. Results of studies were limited by small sample size, short duration of study, or poor quality methodology based on the 2015 systematic review and meta-analysis of 20 studies, the 2014 Cochrane systematic review of 13 trials, and the 2015 single blind randomized controlled trial in patients with recent myocardial infarction. "Tai Chi: A Gentle Way to Fight Stress." http:///ww.mayoclinic.org/healthy-lifestyle/stress-management/in-depts/tai-chi/art-20045184/ (accessed April 22, 2017).

other non-pharmacologic approaches to hypertension, although the varied study methodologies mitigated a definitive conclusion.[269]

While Ttai chi may produce health benefits, Ttai chi may also induce spiritual harm, according to those who challenge the utilization of Tai chi.[270] Tai chi incorporates the Chinese concepts of opposing forces within the body and a vital energy or life force referred to as "qi" through the body. The practice of Ttai chi is through to support a health balance of in and yang, aiding the flow of qi.[271] This theoretical basis provides a basis for the cautious use of tai chi as with other energy therapies. Exposure to the occult may occur through the introduction of the universal energy field, and Universal Consciousness which may be espoused by some practitioners.[272]

Opponents of Tai chi also challenge study results based on the fact the mechanism of improvement is not determined; whether the result is based on life energy intervention or the exercise of Tai chi. Additionally, when Tai chi was compared to a control with no intervention, [273] depression and well-being scores were better than the control group. However, when Ttai chi was compared to a walking group and a control group, there was no psychological differences noted, therefore the evidence for tai chi over another exercise program is weak.[274]

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[269] Gloria Y Yeh, Chenchen Wang, Peter M. Wayne, and Russel S. Phillips, "The Effect of Tai Chi Exercise on Blood Pressure: A Systematic Review," *Preventive Cardiology* 11, no. 2 (Spring 2008): 82, 88.

[270] O'Mathúna and Larimore, 259.

[271] "Terms Related to Complementary and Integrative Health." "Tai Chi: An Introduction. https://nccih.nih.gov/health/taichi/introduction.htm (accessed April 29, 2015).

[272] O'Mathúna and Larimore, 259.

[273] Ibid.

[274] O'Mathúna and Larimore, 259.

## Yoga

Yoga is a practice of postures (*asanas),* breathing exercises (*pranayama***),** and meditation meant to foster the mind-body connection.[275] With a history of practice which reaches back to the first or second century BCE in India, Yoga has gained popularity in the United States in the past 100 years. Reported to be practiced by 15.8 million Americans,[276] Yoga may be taught at health clubs, hospitals, senior citizen centers, and even Christian churches.

Subject to Western scientific inquiry for many years, the scientific literature on Yoga is limited in scope and quality, and existing studies have not established the mechanism of action in the modality of yoga. Theories for the benefits include the quieting of negative impulses of the mind improves the functioning of the musculoskeletal system, improved flexibility and strength and reduced postural guarding and other habitual physical behaviors associated with chronic pain, increased mental focus, improved body awareness, and activity and relaxation exercise can lead to stress reduction.[277]

Although deemed in some cases to be effective for some conditions, such as hypertension and epilepsy, many studies report only limited populations, short duration of study, and/or lack of appropriate blinding. Additionally, Yoga practices vary, making comparisons difficult. However, good evidence supports that yoga has been found to

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[275] Genevieve Verrastro, "Yoga as Therapy: When is it Helpful?" *The Journal of Family Practice* 63, no. 9 (September 2014), E1. "Terms Related to Complementary and Integrative Health."

[276] Ibid.

[277] Tan et al., 214.

reduce symptoms of low back pain,[278] anxiety and depression, and fair evidence has been found yoga to be useful with symptoms of asthma, menopause, hypertension, and balance and stability in the elderly.[279] Yoga has been identified as a strategy for coping with diagnosis of chronic illness to sleep disorders.[280]

Further support of Yoga is generated through the systematic reviews of randomized controlled trials found Yoga interventions, both as a stand-alone intervention or as an adjunct treatment, typically improved overall symptom scores for anxiety and depression. The reduction, which was seen across diverse populations, ranged from 12% to 76%, and average net reduction of 39%.[281]

The Institute for Clinical Systems Improvement and the Canadian Network for Mood and Anxiety Treatments recommend yoga as an effective adjunctive treatment to decrease symptoms of depression. The Veterans Health Administration and the US Department of Defense has recommended Yoga as a potential adjunctive treatment for the hyperarousal symptoms of post-traumatic stress disorder (PTSD). Additionally the Work Loss Data Institute recommends Yoga for workers compensation conditions

[278] Tan et al., 205 reported three studies on chronic low back pain suggested a positive benefit to yoga as evidenced by decreased pain and improved functional disability as compared to a control group. Yoga may be an appropriated treatment in some cases for low back pain which is often a stress related musculoskeletal condition however there is not enough evidence to suggest it as a routine intervention. Additionally, a study on carpal tunnel syndrome demonstrated statistically significant differences in grip strength, pain intensity, and Phalen's sign as compared to the control group. A study of hand osteoarthritis reported statistically significant improvement in pain, joint tenderness, and finger range of motion with yoga intervention.

[279] Verrastro, E1.

[280] "Pill-free Way to Reduce Pain and Improve Balance and Flexibility," *Harvard Health Letter* (March 2014).

[281] Irene Belle Skowronek, Anne Mounsey, and Lara Handler, "Clinical Inquires: Can Yoga Reduce Symptoms of Anxiety and Depression?" *The Journal of Family Practice* 63, No.7 (July 2014), 398.

including occupational stress, major depressive disorder, PTSD, and other mental disorders.[282]

Asthma is an obstructive pulmonary disease which may be caused by stressors such as exercise, triggers found in the workplace or other environment. It may be associated with congestive heart failure, medication, or there may be genetic association such as cystic fibrosis. With the attention to breathing and its mechanics, one might suspect Yoga is a natural addition to conventional asthma therapy. However, review of studies demonstrated mixed response. While some studies reviewed found significant improvements in spirometric measurements in patients who practiced Yoga techniques, some showed some improvement in the Yoga group as compared to usual therapy, while other studies showed no improvement with Yoga over conventional treatments.[283]

As conventional medical therapies for symptoms of menopause have been found to have adverse effects, Yoga has been investigated as an alternative therapy, primarily with respect to hot flashes. However, there is little evidence Yoga reduced hot flashes and when compared to other forms of exercise, there was statistically no difference. However, those in the Yoga group did show lower stress levels and decreased overall symptoms. Additional review of research projects showed that yoga interventions were not efficacious for somatic, vasomotor, or urogenital symptoms of menopause; however, it was somewhat efficacious for psychological symptoms associated with menopause.[284]

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[282] Ibid., 399. 407.
[283] Verrastro, E4.
[284] Ibid., E5.

Review of studies with meta-analysis of the use of Yoga therapy which included *asanas* intervention and the diseases of hypertension and pre-hypertension, showed a decrease in both diastolic and systolic blood pressures when compared to usual treatment but not to other exercise therapies. The research conclusion was Yoga was likely to be effective for lowering blood pressure as other types of physical activity. Significant blood pressure decrease was found in a pilot study which randomly selected subjects into a twenty-four week lyengar yoga class or into the control group education about lifestyle modification.[285]

Yoga is thought by some to be a helpful strategy for injury prevention in the elderly with the focus on strength, balance, and body awareness of Yoga. However, there are not a significant number of controlled trials to make that claim.[286]

Locating an appropriate Yoga teacher may be a challenge to the consumer due to the lack of standardized credentialing of practitioners. The International Association of Yoga Therapists was founded in 1989 to define Yoga therapy and organize Yoga practitioners. The association published a suggested 800 hour curricular of study, but these standards have not permeated the industry.[287] At least 200 hours of certification and training to work with older adults is suggested for those working with the senior population.[288]

Those who support Yoga refute Yoga is a religion; rather it is merely a group of exercises whose aim is to improve strength, balance, posture and flexibility, and achieve

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[285] Ibid.
[286] Ibid,
[287] Ibid., E2.
[288] "Pill-free Way to Reduce Pain and Improve Balance and Flexibility."

complete peacefulness of mind and body, a method to counteract stress and anxiety.[289] . Recognizing its origination in India, Yoga is explained to be a series of postures and breathing techniques that include an element of awareness of the body, sometimes referred to as medication in motion.[290] Yoga has been found to decrease symptoms of depression, alter brain waves, and lower blood pressure, according to the National Institute of Health.

For those suspect of Yoga as more than just an exercise program, it is a deeply religious practice. The word *yoga* literally means "union," and union with the "divine is implied. An important part of the Hindu religion, the aim of Yoga is to achieve spiritual enlightenment achieved through the integration of the physical postures and breathing exercises. The physical postures, known as *asanas* are thought to relax the mind and body and bring them to spiritual harmony. The breathing exercises, known as *pranayamas*, are designed to regulate the flow of *prana*, the Hindu term for life energy.[291]

Through this practice a meditative state is sought, from which the Great Unconscious occurs leading to spiritual enlightenment. The apex of the enlightenment is known as "Kundalini arousal." Found in Hindu mythology, Kundalini is a serpent goddess who rests at the base of the spine. However when aroused, Kundalini travels up the spine activating a person's *prana* and clearing the person's *chakras* (energy

[289] Bauer, 13.
[290] "Pill-free Way to Reduce Pain and Improve Balance and Flexibility.
[291] O'Mathúna and Larimore, 271.

transformers). Ultimately the head *chakra* is reached by Kundalini which opens the practitioners to enlightenment from occult sources and spirit guides.[292]

Christian spiritual advisors may find Yoga to be antithetical to biblical Christianity due to the goal of union with the divine. Although some may be resist the temptation to explore the worldview behind Yoga, concern may exist for those whose faith may be less firm, and those who are vulnerable and unable to resist the spiritual attraction of Yoga.[293] Following the advice of Paul in the first letter to the Corinthians chapter 8, one should avoid any action that might harm another, pastoral care providers may be advised to discourage Yoga as a complementary therapy.

[292] Ibid.
[293] Ibid., 272.

# CHAPTER 5

## What Would Be a Faithful and Effective Response: Specific Recommendations for Enriched and Faithful Praxis

The final task of practical theology is the *pragmatic task.*[1] Used to form and enact effective strategies to positively influence a situation, this task provides a framework for effecting a change.[2]

The World Health Organization (WHO) defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[3] Faith community nursing embraces this notion of health through the philosophy of wholistic health care, which is based on the understanding that an individual is an interconnected unity, and physical, mental, social, environmental, and spiritual factors need to be considered in interventions.[4] Although all nurses should address to some degree the bio-psycho-social-spiritual dimensions of a client, "the intentional care of the spirit" differentiates faith community nursing from the general practice of nursing. This unique focus requires the faith community nurse to provide spiritual care, defined as "the practical expression of presence, guidance, and interventions, individual or communal to support, nurture, or encourage an individual's or group's ability to achieve wholeness; health; personal, spiritual, and social well-being;

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[1] Richard R. Osmer, *Practical Theology: An Introduction* (Grand Rapids, MI: William B. Eerdmans Publishing Co, 2008), 4.

[2] Ibid., 175-176.

[3] *Constitution of the World Health Organization* (New York: World Health Organization, April 7, 1948), preamble. http://who.int/about/definition/en/print.html (accessed November 6, 2015).

[4] Sharon T. Hinton, "History and Philosophy," *Foundations of Faith Community Nursing Curriculum* (Memphis, TN: Church Health Center, 2015), 2.

integration of body, mind, and spirit; and a sense of connection to self, others and a higher power."[5] The faith community nurse must be cognizant of this charge when considering appropriate interventions.

The use of complementary modalities is not unanimously accepted. Concerns are voiced by members of the medical/scientific community as well as members of the Christian ministerial community. The scientific jurisdiction may question foundational evidence for the practice. Church officials fear a practice may not be grounded in Christianity, which may ultimately sway an individual and be harmful to the soul. The practitioners who believe they cannot help patients without the introduction of ancient Eastern of New Age faith systems may also present a challenge.[6]

The faith community nurse may be approached by a client in search of healing, a process of integrating the body, mind, and spirit to bring about wholeness, health and a sense of spiritual well-being, although a disease may not be cured,[7] through the use of complementary therapies. Two questions may arise. First, as a faith community leader, how does one advise the faith community with respect to the use of complementary interventions? Secondly, as a member of the faithful, can one access complementary interventions and remain a faithful servant? These types of questions led to the question of this thesis project, "What process, which is both evidence-based and theologically consistent with the Roman Catholic faith tradition, should be used by faith community

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[5] *Faith Community Nursing: Scope and Standards*, (Silver Spring, MD: American Nurses Association, 2012), 57-58.

[6] Dónal O'Mathúna and Walt Larimore, *Alternative Medicine: The Christian Handbook* (Grand Rapids, MI: Zondervan, 2007), 29.

[7] *Faith Community Nursing: Scope and Standards*, 55.

nurses, to determine the decision to affirm or refute a particular complementary medicine therapy when approached by a congregant?"

This chapter will suggest a praxis to address the aforementioned question. The praxis presented was developed through reflection on the current praxis perceived through the interviews of the study participants as presented in Chapter 2, looking at potential reasons for the current praxis as presented in Chapter 3, in consideration with factors which influence the standards of practice of the faith community nurse presented in Chapter 4. As Faith Community Nursing requires dual competencies of professional nursing and ministerial practice,[8] the praxis must honor both disciplines. This praxis has a limited range as it will be viewed using documents of the Roman Catholic Church which may not be universally accepted. It will be tested against eight specific therapies queried in this thesis project. It is hoped, however, this praxis may be found valuable for contemplation by faith community nurses when considering other interventions.

## Praxis Considerations

### Summary of Professional Considerations

There is no universally accepted definition of profession, nor unanimously accepted characteristics of a profession. In fact, discussion continues as to the

[8] Sheryl S. Cross, "Developing Dual Competencies: A Personal Perspective," in *Parish Nursing: Development, Education, and Administration,* ed Phyllis Ann Solari-Twadell and Mary Ann McDermott(St. Louis: Elsevier Mosby, 2006), 138.

classification of nursing and ministry as occupation or profession. For the purposes of this thesis-project, this writer contends faith community nurses are subject to professional behavior. The following attributes of a profession were elicited from literature review.[9]

1. A sense of call to their field of practice.
2. Dedication to service to those for whom their care is entrusted.
3. Appropriate education with specialized knowledge and skill.
4. Accountability to the community, providing care within standards of practice
5. Ethical practice within a professional code of ethics.[10]
6. The use of a professional organization as a primary reference point, self-regulation, and professional autonomy.[11]

Whether considered occupation or profession, faith community nursing is perceived by multiple stakeholders as ministry. Ministry has additional or nuanced characteristics within the construct of service.[12] These include but may not be limited to

1. Advocacy for the mission of the church, serving the Kingdom of God.
2. Public action and witness on behalf of the Christian Community, not as an individual rather as an officer of the church.
3. Gift of the Spirit.

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[9] Sources consulted included: Richard M. Gula, *Just Ministry* (New York: Paulist Press, 2010): 22-43, Stacy C. Hountras, "What Guides Your Nursing Practice?" *Journal of Christian Nursing*, 32, no.3 (July-September 2015): 179, Joe E. Trull and James E. Carter, *Ministerial Ethics: Moral Foundation for Church Leaders, 2nd Edition* (Grand Rapids, MI: Baker Academic, 2004), 39-40.

[10] Richard M. Gula, *Just Ministry* (New York: Paulist Press, 2010): 42-43. Gula notes professional codes can not be expected to solve all ministerial situations, codes have limitations. Codes often focus on attitudes and practices of the individual to the exclusion of social structures which exert influence over them. Codes require interpretation and the notion that codes can prescribe specific actions in circumstances can encourage legalistic and minimalist interpretations. With respect to the Church, cultural changes may be required to be receptive to the evaluation of ministerial performance.

[11] Gula, 23, Although some scholars may reject this attribute applies to ministry, this does apply to the practice of nursing.

[12] Gula, 34-37. Thomas F. O'Meara, *Theology of Ministry: Completely Revised Edition* (New York, Paulist Press, 1999): 141-149.

4. Diverse services.

5. Fiduciary duty, commitment to the other's best interest.

Ministry is enhanced by professionalism, commitment to theological and pastoral competence, good moral conduct, dedication to service, and accountability to the community.[13] Therefore, the above-mentioned attributes must also be considered in the activity of ethical decision making process by the faith community nurse.

## Summary of Nursing Considerations

Faith community nurses are registered nurses with active licenses in the state in which they practice and knowledgeable in both professional nursing and spiritual care.[14] In addition to the particular state of practice regulations, this specialty practice requires that the nurse adhere to the *Faith Community Nursing Scope and Standards of Practice* and the *Code of Ethics for Nurses with Interpretative Statements* set forth by the American Nurses Association.[15]

An ethical response to an individual's question regarding the use of a complementary therapy practice requires the synthesis of multiple considerations by nurses. Excellent clinical care requires an understanding of the ethical issues embedded throughout nurse/client encounters, as technical and moral aspects of client care cannot

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[13] Gula, 24.

[14] *Faith Community Nursing: Scope and Standards*, 5.

[15] Marsha D. Fowler, "Faith and Ethics, Covenant and Code: The 2015 Revision of the ANA Code of Ethics for Nurses with Interpretive Statements, *Journal of Christian Nursing* 34, no. 4 (October-December 2017): 217, 220. The Code is one non-negotiable standard universally applicable to all nurses, in all venues, in all domains of nursing practice. The interpretive statements are normative statements of how the provisions ought to or must be applied. No statements within the Code are contrary to Christian values.

be separated.[16] Faith community nurses must reflect on the generally accepted ethical principles relevant to medical care, which include beneficence, nonmaleficence, respect for autonomy, and justice. Other principles such as empathy, compassion, fidelity, integrity, and other virtues are included in the landscape of decision making by a nurse.

Care of the faith community member requires a balance and intersection of care of the spirit and care of the body. Whether the considered treatment falls within the sphere of conventional medicine or complementary medicine, the evidential support of the intervention should be evaluated. Recommendations and decisions for health care should be evidence-based.[17]

Nurses are taught the nursing process that is to perform nursing assessments with the application of step sequencing, from the entry into their education. When these tools are applied in the practice setting, outcomes are improved.[18] The nursing process includes collecting subjective and objective data, assessing the data, designing a plan to address the assessment, and the evaluation of the plan.

The nursing process is consistent with the current standard of application of evidence –based practice in health care. Evidence practice includes the right question for query, gathering evidence, appraising the evidence, application of the implementations which offer the best opportunity for positive outcomes, evaluation of the outcomes, and dissemination of information obtained through the process.[19]

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[16] Albert R. Jonsen, Mark Siegler, and William J. Winslade, *Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine, 8th edition* (New York: McGraw Hill, 2015): 1,3.

[17] Dónal O'Mathúna and Walt Larimore, *Alternative Medicine: The Christian Handbook* (Grand Rapids, MI: Zondervan, 2007), 25, 29.

[18] JoAnn Mick, "Call to Action: How to Implement Evidence-based Nursing Practice," *Nursing 2017* 47, no. 4 (April 2017): 37-38.

[19] Ibid., 39.

This thesis-project writer supports the notion the scientific evidence of benefit must be considered in the decision to use complementary medicine therapies. However, when attempting to provide the best evidence-based, faithful response, challenges remain. The quest for scientific rationale to explain phenomena continues. Information is not static, but dynamic, conclusions may be confronted by new evidence and insight. While the criteria for judging whether one should use a particular natural means of healing remain in science, it is acknowledged there may be means of natural healing that have not yet been explained by science.[20]

## Summary of Ministerial Considerations

The interest in complementary medicine interventions is often discussed in terms of dissemination of information to the public and health care providers, but the faith community may also have interest in the discussion of these interventions. Christian faith community nursing practice is ministerial,[21] assumes endorsement by the faith community, and this endorsement implies credibility.

Each faith tradition has particular beliefs, traditions, customs, rituals, and prayers that are related to health, illness, healing, and being in right relationship with a higher power.[22] Christianity identifies the higher party as the Triune God. The requirement for a

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[20] United States Conference of Catholic Bishops, Committee on Doctrine. Guidelines *for Evaluating Reiki as an Alternative Therapy*. Washington DC: United States Conference of Catholic Bishops, March 25, 2009, #6.

[21] O'Meara, 150. A definition of ministry is "the public activity of a baptized follower of Jesus Christ flowing from the Spirit's charism and an individual personality on behalf of a Christian community to proclaim, serve, and realize the kingdom of God." Faith community nursing is not, however, exclusive to Christian faith communities.

[22] Hinton, 8.

knowledge and skill base cannot be waived, as professional ethics require ministers present accurate information. Therefore, ministers should explore the state of particular interventions so they relay accurate information to congregants. However, while acting in a ministerial situation it is paramount the ministry and mission of Jesus Christ be recognized as the source of ministry.[23]

Beyond the presentation of factual information and rules for action, the importance of the character of the individual Christian minister must be considered, as the minister brings herself or himself to each ministerial situation.[24] Authentic spirituality affects the way that one lives his/her life and Christian tradition has expressed virtue as the way in which the Spirit inspires. Virtue ethics brings together what we do with who we are. It is concerned with the character of the minister, attentive to motives, intention, disposition, and perspective, and cultivates a ministerial character that inclines the participant to do what is fitting in situations of ambiguity. The Christian minister, should be guided not only by the question, "What should I do?" but also by the questions "Who am I?" and "What sort of person do I want to become?" Who we are shapes what we do, and what we do shapes who we become.[25]

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[23] Edward P. Hannenberg, *Ministries: A Relational Approach* (New York: The Crossword Publishing Company, 2003): 41. Richard M. Gula, *Just Ministry* (New York: Paulist Press, 2010): 45.

[24] Gula, 45.

[25] Richard M. Gula, *The Way of Goodness and Holiness: A Spirituality for Pastoral Ministers* (Collegeville, MN: Liturgical Press, 2011): 25-26. Gula, *Just Ministry*, 45-47.

## Summary of Considerations Regarding the Individual

Care of the individual parishioner is impetus and focus of this thesis-project. The crucial feature of a clinical encounter is the therapeutic relationship between nurse and patient. Ethical responsibilities envelop this relationship, and priority must be given to the interest of the patient. In many cases ethical quandaries do not ensue as the client and nurse share the goal to resolve a problem, but this is not always the case. An ethical question may arise if there is doubt about the correct action based on conflict of ethical responsibilities.[26]

In most cases, a question regarding participation in a complementary therapy modality will be initiated by a parishioner. As a parishioner of a faith community, the response by a faith community nurse necessitates theological consideration in addition to considerations driven by the practice of nursing. Advocacy for the client in light of God's Word in Jesus Christ in concrete situations in the life[27] is the charge of the faith community nurse. Assessment of the individual's spirituality is also important, as what one person might feel acceptable, another might find scandalous.

The interconnectedness between healthcare, medicine, and religion has been recognized throughout recorded history. History shows that the first hospitals of the countries of the West were founded by religious institutions and staffed by religious orders. Throughout the Middle Ages through the French Revolution, physicians were

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[26] Jonsen, Siegler, and Winslade, 1-2.

[27] Jean Bokinskie, "Ethical Issues," in *Foundations of Faith Community Nursing* (Memphis, TN: International Parish Nurse Resource Center, 2014), 10, Gula, *Just Ministry*, 32.

often clergy. The separation of medicine and religion, as discrete entities, is a relatively new concept, and the separation is seen more prominently in developed countries.[28]

Studies show significant relationships between religion/spirituality and better health, and wholistic healthcare requires recognition of the relationship. Religions/spiritual beliefs are commonly used by patients to cope with illness and other stressful changes. Research also shows that people who are more religious/spiritual have better mental health and adapt more quickly to health problems compared to those who are less spiritual/religious.[29]

*Helping Clients Navigate*

While some wellness and disease prevention activities can appear to be clear cut, navigating the medical system can also be a daunting task in other circumstances. This undertaking can be further complicated factors such as the plethora of available information, some of which may lack credibility, complicated funding systems, and diverse opinions. Clients may turn to the faith community nurse for assistance in the determination as to whether to employ the use of complementary medicine therapies.

Faith community nursing honors the principle that an individual is a bio-psycho-social-spiritual being, aspects which cannot be isolated, but rather intersect and interact. Therefore, the evaluation of a complementary medicine therapy should include both clinical and spiritual considerations.

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[28] Harold G. Koenig, "Religion, Spirituality, and Health: The Research and Clinical Implications," *ISRN Psychiatry* (2012), 1.

[29] Koenig, "15.

Evidence-based practice includes both scientific evidence and values and preference judgements in clinical management decision.[30] From a clinical perspective, the decision whether to use a complementary medicine therapy should include the reasons for the therapy, and scientific evidence for the use of the practice. The clinician must remember that scientific understanding is continually being enhanced. For instance, transcutaneous electrical nerve stimulator (TENS) once thought to be a complementary medicine therapy is now widely used in hospitals and pain care settings and no longer considered to be a complementary modality by most practitioners.[31]

Safety is always a priority in nursing practice. With respect to complementary medicine therapies, faith community nurses should encourage congregants to inform their primary care provider of use of the therapy.[32] For a care professional to assess the full dimension of one's health, an individual should tell their health care providers about the use of any complementary therapy approaches.[33]

From a religious perspective, a guiding question to assess the use of a complementary therapy medicine therapy can be, "What effect will this therapy have on the coherence and integrity of my faith?" Non-Catholic resources should not be completely rejected as there is a difference between syncretism and enrichment; rather,

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[30] Gordon Guyatt, Deborah Cook, and Brian Haynes, "Evidence Based Medicine Has Come a Long Way," *British Medical Journal* 329 (October 30, 2004): 990.

[31] Gabriel Tan, Michael H. Craine, Matthew J. Bair, M. Kay Garcia, James Giordano, Mark P. Jensen, Shelley M. McDonald, David Patterson, Richard Sherman, Wright Williams, and Jennies C. I Tsao, "Efficacy of Selected Complementary and Alternative Medicine Interventions for Chronic Pain," *Journal of Rehabilitation Research and Development* 44, no. 2 (November 2, 2007): 199.

[32] A survey of 6068 patients with chronic musculoskeletal pain found that 35% of those using acupuncture and 42% of those using chiropractic care had not discussed the use with their primary care providers. It should also be noted that many stated they would share the information with their providers, if asked. "Alternative Therapies: Don't Ask, Don't Tell," *Nursing2015* 45, no. 10 (October 2015): 28.

[33] "Tai Chi: An Introduction." https://nccih.nih.gov/health/taichi/introduction.htm (accessed April 29, 2015) .

there is a need for discrimination, discernment, and sometimes rejection[34] when evaluating a practice.

Christians may be advised to avoid energy medicine as they are rooted in Eastern religions and esoteric Western philosophies which often counter Christian teaching. These practices may expose recipients to spiritual forges and practices that are not of God.[35] Yet some therapies within the field of energy medicine have a physical component, which can be separated from the energy medicine philosophy. Where evidence is clear, and the Eastern philosophy may be separated from the physical component, use of therapy may be considered.[36]

## Summary of Ethical Considerations

Ethics involves clarification of what should or ought to be done by an individual and/or society, or what is right or wrong. As previously identified, ethical practice is demanded by the two disciplines in which faith community nursing is rooted and practices, ministry and nursing. For the Christian minister, an ethical discipline of Christian morality in relation to their clients, colleagues, and community is demanded by the Gospel.[37]

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[34] Heather Grennan Gary, "Spiritual exercises: Can Other Religious Practices Strengthen Your Catholic Core?" http://www.uscatholic.org/print/27150 (accessed February 2, 2015). This notion is attributed to Father Thomas Ryan, director of the Paulist Office for Ecumenical and Interfaith Relations in Washington, DC, when describing the notion of reincarnation. Citing the themes that run through *Dominum et Vivificantem* (1986) and *Redemptoris Missio* (1990) that the Holy Spirit is present and active everywhere in the world, not just within the church, Ryan presents that there is a difference between syncretism and enrichment.

[35] Dónal O'Mathúna and Walt Larimore, *Alternative Medicine: The Christian Handbook* (Grand Rapids, MI: Zondervan, 2007), 193-194.

[36] Ibid., 195.

[37] Joe E. Trull and James E Carter, *Ministerial Ethics: Moral Foundation for Church Leaders, 2nd Edition* (Grand Rapids, MI: Baker Academic, 2004), 40-41.

Inherent in professional nursing practice are ethical obligations, as well. Nursing ethics, situated within the subset of biomedical ethics, concerns actions of the nurse in relationship with patients and clients,[38] and is foundational to the practice of nursing and its social contract with society. For the purposes of guiding nursing practice, research, and education, ethical obligations and duties are presented by the American Nursing Association in the *Code of Ethics for Nurses with Interpretative Statements.*[39]

Furthermore, ethical practice is embraced by the practice of faith community nursing as exemplified by Standard 7 of *Faith Community Nursing: Scope and Standards* which states, "The faith community nurse practices ethically."[40] An overview of the competencies of the faith community nurse with respect to ethical practice reveals the faith community nurse will guide practice following the ANA's *Code of Ethics for Nurses with Interpretive Statements,* preserve and protect the health care consumer's confidentiality and autonomy recognizing the health care consumer as the core member of the health care team, and assists the healthcare consumer in self-determination and informed decision making. The standard challenges the faith community nurse to contribute to resolving ethical issues concerning the healthcare consumer, take necessary action when illegal or inappropriate behaviors jeopardize the best interests of the health care consumer, advocate for equitable health care consumer care. Finally, competencies of the ethical standard includes the incorporation of ethical and moral theories, principles,

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[38] Bokinskie, 4.

[39] Ibid., 9-10. American Nurses Association. *Code of Ethics for Nurses with Interpretative Statements* ( Silver Spring, MD: American Nurses Association, 2015), xi-xiii.

[40] *Faith Community Nursing: Scope and Standards*, 35.

and models in planning care, and acknowledge and respects the tenets of the faith and spiritual belief system of the health care consumer.[41]

Values, or standards or qualities of a person or a social group, are derived from one's religious beliefs, culture, family, peer group, and work group[42] and play a key role is the discipline of making ethical decisions. Faith community nursing practice is shaped by the values of multiple entities which include professional nursing practice, the faith community, and personal values. Emerging from historical and cultural contexts, religious values are often deeply embedded in the experience of a person, impact choices about life with a view to please God, and command or teach beyond doing what is good for the sake of doing good. Professional values are standards developed and held by a particular professional group. The basic values of the profession and the principles that protect these values are often codified. Personal values are those important to an individual, and often unconsciously influence our choices, judgements, or actions. Personal values are usually an aggregate of cultural, religious, and professional values.[43]

Moral decision making may seem clear; however determination of the right actions in specific cases may seem less clear. Ethical dilemmas, situation where there are at least two equally justifiable courses of action or judgements but a person is uncertain which one to pursue or choose, occur within healthcare settings and the practice of faith community nursing, and ethical analysis must be employed.

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[41] Ibid., 36.
[42] Bokinskie, 5.
[43] Ibid., 6.

Ethical principles which provide sound moral reasons for judgement or action are employed in deliberation of ethical decision making. Faith community nursing practice, guided by The Nightingale Pledge places in highest regard the good of the individual; advocacy is a central nursing ethic.[44] Advocacy requires action to safeguard individuals when their care is endangered, avoids paternalism, and requires assessment for adequate and appropriate health care resources, initiating referrals when appropriate.[45]

Utilization of Christian ethical principles and norms may still leave a question as to action as they can change over time and cannot cover every situation. For those of the Roman Catholic faith, the Roman Catholic Church teaches the primacy of informed conscience.[46] Conscience is generally understood as "a judgment about the morality of an act to be done or omitted or already done or omitted by the person."[47] The *Catechism of the Catholic Church* speaks of "the interior voice of a human being, within whose heart the inner law of God is inscribed,"[48] and moves a person to do good and avoid evil at the appropriate time.[49] The conscience, which includes the perception of the moral principles, enables one to assume responsibility for acts performed.[50]

The importance of following one's conscience cannot be understated. Thomas Aquinas wrote that one must always obey the certain judgment of his/her conscience, and

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[44] Ibid., 10.

[45] Ibid.

[46] For further explanation of the development and elements of an informed conscience, see Chapter 4.

[47]Charles E. Curran, *The Catholic Moral Tradition Today: A Synthesis* (Washington, DC: Georgetown University Press, 1999), 172.

[48] *Catechism of the Catholic Church*, 872.

[49] Ibid., 438, #1777-1778.

[50] Ibid.,, 439, #1780-1781.

to act against one's conscience is to condemn oneself.[51] Alphonsus Liguori enriched the understanding of the primacy of conscience when he wrote that an act of a sincere but invincible erroneous conscience is "not only not wrong, it is also good and even meritorious."[52]

The *Catechism of the Catholic Church* clarifies that some rules apply in every case of choice consistent with conscience. First, one may never do evil so that good may result. Next, the Golden Rule should be applied, "Whatever you wish that men (women) would do to you, do so to them." Finally, charity always proceeds by way of respect for one's neighbor and his (her) conscience. Should one sin against another wounding their conscience, then one sins against Christ. An individual may not do anything that causes another to misstep.[53]

## Proposed Praxis

The question of this thesis-project arose from a practice question, "What process, which is both evidence-based and theologically consistent with the Roman Catholic faith traditions, should be used by faith community nurses, to determine the decision to affirm or refute a particular complementary medicine therapy when approached by a congregant?" To guide practice, a practical theological praxis must do beyond collecting and sorting facts of a question, decisions as to how the problem may be managed must be

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[51] Ibid., #1789, #1790.

[52] Curran, 174. Primacy of conscience and features of decisions of conscience are discussed in more detail in Chapter 4.

[53] *Catechism of the Catholic Church,* #1789, #1789.

included in the approach. However, clinical ethical decision making rarely establishes a clearly right solution, rather it establishes a more right, and more reasonable solution among various options. Although each case is unique, the quest is for a reasoned conclusion based on medical facts and ethical considerations that leads to the good solutions, based on the variables presented.[54]

The proposed praxis embeds an adaptation of *Four Topics*[55] a quadrant model for clinical decision making developed by Albert R. Jonsen, Mark Siegler, and William J. Winslade within the nursing process, a 4-6 step modification of the scientific method which serves as a problem solving model that guides nursing interventions. Merging these two constructs, a decision plan was created for the collection of data which serves as a catalyst for establishing nursing diagnoses, planning, and evaluation while working with clients requesting input as to the use of complementary medicine therapies.

*Four Topics*, referred to as four boxes, provides a structure to sort information gathered for clinical consultation. The boxes, or areas of inquiry, include medical indications, patient preferences, quality of life, and contextual features.[56] Medical indications refer to the diagnostic and therapeutic interventions used to evaluate and treat the medical problem. Patient preferences encompass the choices made by the patient about treatment or the decisions of those who are authorized to speak for the patient when

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[54] Albert R. Jonsen, Mark Siegler, and William J. Winslade, *Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine, 8th edition* (New York: McGraw Hill, 2015): 4-6.

[55] Ibid., 4. This model was developed for use by physicians for ethical clinical decision analysis, however, this author poses that clinical decision making within the larger medical spectrum, and specifically faith community nursing practice, has enough similarities to allow for adaptation of this model without affecting the integrity of this model. It should be noted that faith community nursing is not prescriptive. In some cases, this author will expand the concept attributed to the physician by Jonsen, Siegler, and Winslade to include other health care professionals which include faith community nurses.

[56] Ibid.

the patient is incapable of doing so. Quality of life refers to the degree of satisfaction and well-being, or the degree of distress and malfunction experienced prior to and following treatment. Contextual features identify social, institutional, financial, and legal settings within the setting care takes place or influence medical decisions.

The first focus considers medical indications. These are defined as the facts and their interpretations about the physical or psychological condition. These provide a reasonable basis for clinical judgments, aiming to realize the overall goals of medicine: prevention, cure, and care of illness and injury.[57] This area of inquiry considers the principles of beneficence and nonmaleficience; the goal is to ascertain how the client may benefit by an intervention, and how harm might be avoided.

Questions that help to elicit this assessment concern the medical problem itself, the timeframe of the problem, contraindications for the intervention, goals of treatment, and the probability of treatment success.[58] While medical indication is often straightforward in Western conventional treatment conversation, answers may be less clear with respect to complementary medicine interventions as there may be less scientific data available to rate efficacy of interventions. Clinical decision making rarely allows an answer in which there is pure good and no harm. Therefore, benefit to risk ratio reasoning must be employed to gage the amount of risk permissible to obtain the benefit.[59] Medical indications assessment addresses benefit in its objective medical sense. This information is then molded into a recommendation by a medical professional

[57] Ibid., 12.
[58] Ibid., 9, 12.
[59] Ibid., 13.

based on the goals and values of the client. The recommendation is then assessed by the individual.[60]

In most clinical decision making instances, the goals of the patients and the health care providers align, but that cannot be assumed. Therefore, the preferences of the patient, the choices that persons make when they are faced with decisions about health and medical treatment, is the second topic of consideration in ethical clinical decision making. Individual's choices are swayed by experience, beliefs, and values and informed by the medical professionals' recommendations. The construct of patient preferences acknowledges the principle of autonomy, the moral right of every competent individual to choose and follow his or her own plan of life and actions. Respect for autonomy is an aspect of the larger principle of respect for persons, important to a therapeutic relationship.[61]

To establish patient preferences has more value than just good public relations. Patient preferences have clinical, legal, and psychological implications. Adequate information must be provided to the client for informed consent, and all states require informed consent for treatments, unless an emergent situation.[62] In 1982, the President's Commission for the Study of Ethical Problems in Medicine proposed "shared decision-making" model supporting the research which demonstrated that patients who collaborate with their physicians have greater trust in the doctor-patient relationship, have greater

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[60] Ibid., 48, 50.
[61] Ibid., 49, 51.
[62] Ibid., 53. The mandate of informed consent is not a requirement for faith community nursing, as no treatments are performed by the faith community nurse.

cooperation with the decision implementation, and have grater satisfaction in health care.[63]

Psychologically, the ability to express preferences and have them respected by others is important to feelings of self-worth. Additionally, preference expression provides the practitioner with important influencing information such as fears, fantasies, or unusual beliefs which should be considered in establishing a treatment plan.[64] Questions used to help define patient's preferences concern the information of risks of diagnostic and treatment recommendations and their consent, mental capacity of the individual, preferences verbalized by the patient with capacity or their surrogate when necessary, and the patient's willingness to cooperate with medical treatment and/or concerns.[65]

To complete the assessment of a clinical ethical issue the subject of quality of life must be addressed through the third topic of the *Four Topics* model. Quality of life refers to "that degree of satisfaction that people experience and value about their lives as a whole, and in its particular aspects, such as physical and psychological health,"[66] a relevant consideration in clinical decision making. The subjective nature of assessing quality of life, and the expression of quality of life as a value judgement which is

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[63] Ibid., 51-52. Neither the principle of beneficence nor autonomy create a perfect patient-doctor relationship. A 2007 national survey showed that not all patients prefer a shared decision model. 62% of the patients surveyed preferred a shared decision making model, 28% preferred a consumerism model which highlights autonomy and 9% preferred a paternalistic model.

[64] Ibid., 54.

[65] Ibid., 9. This thesis-project recognizes that not all clients have capacity. However, for the purposes of this project, it will be assumed that faith community members who approach the faith community nurse with respect to complementary medicine therapies have capacity.

[66] Ibid., 112, 116. Quality of life must be defined by the one who lives the life, not by others when possible, and it may change with time. Quality of life is different than sanctity of life which refers to the concept that human life represents the highest value that may be protected and preserved.

expressed in terms of good or bad, better or worse, makes quality of life difficult to quantify. A variety of dimensions which include performance in social roles, physical health, intellectual functioning, emotional state, and life satisfaction or well-being constitute one's quality of life. Quality of life reflects the principle of beneficence, the duty to act in ways that bring satisfaction to other persons.[67]

Questions that may be posed to inform the ethical decision making process with respect to quality of life include the prospects for return to a normal life with or without treatment, when another can judge some quality of life would be undesirable for a patient who cannot express their own judgement, what biases might prejudice the provider's evaluation of life, what specific ethical issues arise concerning improving or enhancing a patient's quality of life, do quality of life assessments raise questions that may affect the treatment plan, are there plans to provide pain relief and provide comfort after life-sustaining interventions are suspended, and the legal and ethical status of suicide.[68] While these questions provide a guide for assessment discussion, they can offer a challenge. For instance, there is no singular definition of "normal life," the description is dependent on the person making the judgement and measurement criteria.

Decisions are not made in a vacuum, so the final topic of contextual features is added to the deliberation. While the medical professional-patient is a personal encounter cloaked in privacy, other factors invade the decisions making process. Therefore, essential to the description, analysis, and resolution of an ethical situation, is the ways in

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[67] Ibid., 111. Jonsen, SIegler, and Winslade note that the principle of beneficence also includes duty to help others in need.

[68] Ibid., 114. These questions represent those to be considered in the broad medical arena, but may not be germane to this thesis-project with respect to complementary medicine therapies.

which professional, family, religious, financial, legal, and institutional factors influence clinical decisions. Contextual features impose responsibilities on the patient and the medical professional, and the ethical task is to assess the factors their importance on a clinical decision.[69]

The moral principles of beneficence, respect for autonomy, and fairness interplay with contextual features. Fairness is a feature of the principle of justice which refers to "moral and social theories that attempt to distribute benefits and burdens of a social system in a fair and equitable way among all participants in a system." Fairness "demands that transactions and relationships give to each participant that which they deserve and can reasonable expect."[70]

Questions relevant to contextual features analysis include concern for conflicts of interest, the interest of other stakeholders in the clinical decision, confidentiality and third party interest constraints, financial considerations, allocation of resources, religious factors which influence a decision, legal issues which affect clinical decisions, clinical research and medication education that affect clinical decisions, public health and safety considerations, and institutional affiliation influence on decision making. Conflict of interest, a term used to describe "a situation in which a person might be motivated to perform actions that his or her professional role makes possible but that are at variance with the acknowledged duties of that role," is an important theme in this line of inquiry Potential conflict of interest is not necessarily unethical, however, when possible,

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[69] Ibid., 165-166.

[70] Ibid., 167. In some cases, veracity, privacy, and fidelity are also included in the principles to be considered.

conflicts of interest should be eliminated or managed so as not to interfere with the therapeutic relationship.[71]

The proposed process presumes that a faith community nurse is approached by a faith community member for the purposes of questioning the use of a complementary medicine therapy. Complementary medicine therapies are used not only for treatment, but also as modalities to promote wellness. As faith community nurses offer education on wellness and disease prevention, a version of this process may also be applicable when discerning the appropriateness of presentation of a particular complementary medicine modality.

## Proposed Praxis Process

### *Assessment*

The first step of the nursing process is assessment, which is driven by the gathering of subjective and objective data. The subjective data comprises the information provided by the client. While this thesis-project presents discrete steps, it is recognized that the collection of information is a more fluid process, and the order of information collection may be less defined in practice. While all relevant circumstances and principles should be considered, the weight of aspects of a case may be nuanced. A principle does not have "weight" in and of itself. Rather the weight of the principle can only be determined in its application to a situation.[72]

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[71] Ibid., 167-169.

[72] Ibid., 5. Jonsen, Siegler, and Winslade give the example that the principle of beneficience/nonmaleficence has carried great "weight" through history however, it may have less "weight" when no known form of treatment can effect a cure.

If a client wishes to discuss a complementary practice modality, the faith community nurse would begin with questions encompassed in the medical indication quadrant of the *Four Topics* model. The nurse may ask a brief medical/health history to provide a foundation for the discussion. Information elicited from the conversation should include reason for the consideration of a therapy and whether the modality intended to support a health and wellness objective. The client's goals and expectations for treatment should be clarified. Generally speaking, the information is gathered to address whether the client would potentially benefit from the intervention, and if potential for harm with the intervention exists. This thesis-project recognizes that the psycho, social, physical, and spiritual facets of an individual may not be divided into distinct units; there is a continual interplay between the spheres. However, for the purposes of this section of exploration, benefit and harm would refer to the physical realm; spiritual harm will be addressed later in the praxis.

Having addressed the medical indication quadrant of the *Four Topics*, the assessment would continue with inquiry of patient preferences, which recognizes the principle of respect for autonomy. For the purposes of this thesis-project, it is assumed tthe individual with whom the faith community nurse has capacity, and has the ability to exercise one's own autonomy. The faith community nurse would question the client's understanding of the potential risks and benefits of the proposed treatment modality. As the faith community nurse is not the practitioner, acquisition of an informed consent would not be required. However, the faith community nurse would want to assess the client's knowledge and assist the client identify any knowledge deficits regarding the therapy.

The next area of exploration is contextual features. The principles of justice and fairness are considered within this *Four Topics* quadrant. Conflict of interest is an overarching theme in this deliberation, and a variety of entities are potential sources. Personal, professional, interprofessional, or business practices may pose concerns with a particular complementary treatment plan. The faith community nurse can help the faith community member determine if there are financial or other resource acquisition conflicts with a particular plan. The faith community nurse can also help the congregant determine conflict of interest exists with legal, research, public health, safety, or institutional affiliation.

Principles of beneficence, nonmaleficence, and respect for autonomy are found through the fourth quadrant of consideration in the *Four Topics* model, quality of life. Through this area of the assessment the faith community nurse can help the faith community member consider the impact of the complementary medicine intervention on the quality of life for the individual. Alternate options would be addressed. This quadrant would potentially have more gravity in treatment arenas, other than complementary medicine, such as experimental trials.

Once the *Four Topics* are explored, further relevant data collection is required to complete the discernment process. First, information regarding the complementary medicine intervention must be explored. Specific questions are offered in this thesis-project, however, it is recognized the areas of consideration are interconnected, and the questions are not mutually exclusive to any one domain. Questions to elicit the necessary data include, but may not be limited to: 1) Was a referral made for this therapy, and if so,

by whom, 2) Is there evidence to support the use of the particular complementary therapy, and if so, what is the level of the evidence, 3) What is involved with the particular therapy, 4) What are the expected benefits to the therapy, 5) What are possible risks, harm, and/or contraindications to participation with the proposed intervention, and 6) Are there alternative treatments for consideration?

Another area to probe is the intended practitioner. Questions for consideration include, but may not be limited to: 1) Does the therapy intervention require professional licensing or credentialing and if so, does the practitioner have the appropriate licensing or credentialing, 2) What is the educational level of the practitioner, 3) What are the professional organizational affiliations of the practitioner, 4) What is the background of the practitioner, and 5) How was the practitioner selected?

The faith community nurse would be responsible to assess the spiritual implications of a complementary medicine therapy, when applicable. Questions may include, but are not limited to: 1) Does the complementary medicine have spiritual roots which may cause concern for the individual, 2) Does the faith tradition espoused by the individual have statements of support or concern for the particular therapy under consideration either denominationally or locally, and 3) Does the individual have spiritual concerns with respect to receiving the prospective therapy?

Financial considerations should be explored. The faith community nurse may discuss with the congregant the mechanism for payment. The inquiry may include, 1) What is the cost/potential benefit ratio, 2) Is the therapy paid for by insurance, and 3) If private pay, what would be the burden to the individual/family?

*Diagnosis*

Informed by the assessment data, the second step of the nursing process is to synthesize the data into a nursing diagnosis. Based on the NANDA Nursing Diagnosis List for 2015-2017,[73] although it is recognized other situations may generate others, potential nursing diagnosis to be addressed may include,

1. Sedentary lifestyle
2. Ineffective health maintenance
3. Ineffective health management
4. Impaired physical mobility
5. Impaired walking
6. Fatigue
7. Risk for activity intolerance
8. Deficient knowledge
9. Readiness for enhanced hope
10. Anxiety
11. Readiness for enhanced decision-making

[73] *NANDA Nursing Diagnosis List for 2015-2017*. https://health-conditions.com/nanda-nursing-diagnosis-list-2015-2017/ (accessed October 22, 2017). NANDA refers to the North American Nursing Diagnosis Association. The 2015-2017 accepted disturbed energy field as a nursing diagnosis for development and clinical validation.

12. Decisional conflict

13. Decision making

14. Moral distress

15. Risk for enhanced religiosity

16. Risk for spiritual distress

17. Spiritual distress

18. Impaired comfort

19. Acute pain

20. Chronic pain

The specific diagnosis or diagnoses would form the basis for the development of a plan to reach the desired outcomes of the individual.

*Implementation*

The third step of the nursing process is to develop a plan to be implemented. In the case of an inquiry regarding the use of a complementary medicine therapy this activity would include assisting the parishioner come to a decision which is both evidence-based and theologically sound. If questions remain regarding the mechanism, safety, or effectiveness of a therapy practice, the first step would be to gather the necessary information to inform the decision to be made. Once the necessary information

is obtained, the following decision plan may be used to guide support or rejection of complementary therapeutic practices.

1. Is the therapy appropriate to the goals to be achieved?

    No- Stop- consider another option  Yes- next step

2. Is there reliable scientific evidence which supports the therapy?

    No- Stop- consider another option  Yes-next step

3. Is the therapy medically safe?

    No- Stop-consider another option  Yes-next step

4. Is there a credentialed provider?

    No- Stop until a credential provider found  Yes-next step

5. Is this theologically/spiritually safe?

    No- Stop  Yes-may continue

    Unsure-may require more information, prayer, use of conscience

Reasons which may challenge spiritual welfare include the potential of dishonoring the body, practices forbidden by Scripture, assigning a healing power to a person or provider rather than Jesus Christ-the true healer, practices leading an individual away from the Triune God, or the possibility of bringing spiritual harm of others.[74]

6. Would this therapy financially feasible?

No-Stop until funding can be established Yes-next step

The principles of advocacy, evidence based practice, physical and financial stewardship, conscience, consistent with Commandments to Love God and Love and Serve others are supported through the proposed model. As a guide decision making, not every situation will fit neatly into the model, decisional conflict may remain. For the Roman Catholic nurse, the final check is an informed conscience which he/she is obligated to follow.[75]

**Application of Praxis for Specific Complementary Medicine Therapies**

The aforementioned decision tree provides a guide to a faith community nurse to assist a congregant in determining the appropriateness for use of a complementary medicine therapy. The scientific and theological issues of the specific therapies addressed in this thesis project are provided for application of the praxis.

Acupuncture

The term “acupuncture” describes a family of procedures which involve the stimulation of points on the body using a variety of techniques. The most studied acupuncture technique involving penetration of the skin with thin, solid, metallic needless

[75] See Chapter 4, pages 33-40 for discussion of informed conscience.

manipulated by hands or by electrical stimulation[76] is generally considered to be a safe procedure and the incidence of adverse effects is substantially lower than medications and/or other medical procedures for the same conditions.[77] While claims support acupuncture as efficacious for a number of conditions,[78] evidence has supported the use to help manage certain pain conditions such as chronic low-back pain, myofascial pain, neck pain, and osteoarthritis/knee pain. Tension headaches and migraine headache prevention may be appropriate indications for the use of acupuncture. Needle acupunctures is efficacious for adult postoperative and chemotherapy nausea and vomiting and probably for nausea of pregnancy, and post-operative dental pain.[79]

The safety of the procedure, however, can be jeopardized by use of non-sterile needles,[80] and improperly delivered treatments, in which case infections, punctured organs, collapsed lungs, and injury to the central nervous system can result.[81] Selection of a credentialed acupuncturist with appropriate education and training standards is an important consideration.

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[76] "Acupuncture: In Depth." https://nccih.nih.gov/health/acupuncture/introduction.htm (accessed March 17, 2017).

[77] National Institutes of Health. "Acupuncture." *NIH Consensus Statement* 15, no. 5 (1997): 9. Medications and other medical interventions have the potential for negative side effects yet the evidence for the therapies is no better than that of acupuncture.

[78] Ibid., 2. The conclusions of the panel find that many studies of potential usefulness have been done, but equivocal results were found due to design, sample size, and other factors in the studies such as appropriate controls, placebos, and sham acupuncture groups. Less convincing yet positive results have been found with addiction, stroke rehabilitation, carpal tunnel syndrome. If used for asthma or addiction it should be part of a comprehensive management program.

[79] "Acupuncture," *Holistic Health Promotion and Complementary Therapies: A Resource for Integrated Practice eds.* Simon Weavers an Loretta Haught (Gaithersburg, MD: Aspen Publishers, 1999):2-7:1. National Institutes of Health, "Acupuncture, " 7,9.

[80] The needles, once considered "experimental medical devices," are now regulated by the Food and Drug Administration who also regulates devices such as surgical scalpels and hypodermic syringes. National Institutes of Health, "Acupuncture," 3-4.

[81] "Acupuncture: In Depth."

Used by millions of American patients, this modality has been a part of Traditional Chinese medicine more than 2500 years, and is practiced by some conventional medical practitioners such as physicians, dentists, as well as acupuncturists. The general theory of acupunctures is based on the premise that there are patterns of energy flow (Qi) in the body which are essential to health, and disruption in the flow is believed to be responsible for illness. The goal of the acupuncture practitioner is to rebalance energy flow.[82]

Western practitioners observe that acupuncture can cause multiple biological responses which may occur locally or at a distance which may lead to activation of pathways affecting systems throughout the body and there is evidence that alterations in immune function may be produced through acupuncture. Endorphins that regulate pain perception may be released, a counter irritant mechanism may bring relief, a placebo effect may be present, or pain suppressing neurotransmitters may be released.[83] The exact mechanism of therapeutic effect remains a mystery, the anatomy and physiology of the acupuncture points, and the definition and characterization of these points remains controversial.[84]

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[82] Brent Bauer, ed., *Mayo Clinic Book of Alternative Medicine*, 121.

[83] Bauer, 121, O'Mathúna and Larimore, 129-130.

[84] "Acupuncture," *Holistic Health Promotion and Complementary Therapies: A Resource for Integrated Practice* 2:7:2,6. National Institutes of Health, "Acupuncture, " 3,11. Richard L. Street, JR., Vanessa Cox, Michael A Kallen, and Maria E. Suarez-Almazor, "Exploring Communication Pathways to Better Health: Clinician Communication of Expectations for Acupuncture Effectiveness, *Patient Education and Counseling* 89, no. 2 (November 2012): 250 concluded that a clinician's communication about treatment efficacy early in therapy influenced patients; judgments of acupuncture's effectiveness over the course of treatment which in turn predicted patient reports of pain and functions 6 weeks post treatment.

Acupuncture focuses on holistic, energy-based approach to an individual, and not a disease-oriented diagnostic and treatment model,[85] but works without a religious component.[86] This practice may be an acceptable choice for Christians; however spiritual connections should be avoided.[87] When acupuncture needles are used to manipulate life energy in a practice similar to a spiritual practice, spiritual concerns are raised.

Appropriate vetting of a practitioner is a major consideration with acupuncture. The spiritual persuasion of the practitioner is important, as those embedded in Chinese medicine may attempt to sway the individual's worldview. Additionally, some practitioners may call on spiritual powers, other than the Triune God, exposing an individual to occult influences.[88] As with other medical practices, it is important the practitioner be credentialed by the local State agency. This helps to identify qualified practitioners and promotes educational standards.[89]

*Evaluation*

This would be an appropriate complementary medicine therapy for a faith community nurse to support providing acupuncture is appropriate for the condition under consideration such as treatment for nausea and vomiting following chemotherapy or surgery, to relieve dental pain, headache relief, or chronic back pain relief. This therapy

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[85] National Institutes of Health, "Acupuncture," 13,18. Biochemical and physiological studies have provided some insight into acupuncture, but acupuncture is based on a model of energy balance which may provide new insights to medical research.

[86] Susan Brinkman, *Is Acupuncture Acceptable for Catholics?* http://www.catholicculture.org/culture/library/view.cfm?recnum=8758 (accessed August 31, 2014) .

[87] O''Mathúna and Larimore, 72, Brinkman.

[88] O'Mathúna and Larimore, 131.

[89] National Institutes of Health, "Acupuncture," 13, O'Mathúna and Larimore, 131.

is essentially safe if due diligence is done to find a qualified practitioner, one who has appropriate credentials, and one who does not impart Eastern philosophy which some might find disconcerting.

## Biofeedback

Increasing in popularity in the United States among the public, insurers, and medical professionals, biofeedback is a mind-body technique which teaches an individual to modify their physiology for the purpose of improving their physical, mental, emotional, and spiritual health through the use of monitoring devices. This technique requires active involvement on the part of the individual; it is not a passive therapy. Practice between sessions may also be required by the treatment plan.[90]

One's body is constantly adjusting to feedback received from our body, and from our environment. Through biofeedback clients can see what is happening to their body in real time, and are taught to control responses once thought to be involuntary such as heart rate, respiratory rate, skin surface temperature, skin conductance, and heart rate variability.[91] Biofeedback also aids an individual become aware of thoughts, feelings,

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[90] Dana L. Frank, Lamees Khorshid, Jerome F. Kiffer, Christine S. Moravec, and Michael G. McKee, "Biofeedback in Medicine: Who, When, Why and How?" *Mental Health Family Medicine* 7, no. 2 (June 2010): 85, 87. Mind-body medicine refers to approaches that help harness the power of the mind to prevent illness, decrease disease, enhance healing, and promote well-being; to positively influence the mind to improve the health of the individual. The core components of mind-body medicine are to restore the mind to a state of peaceful neutrality, and to use this peaceful mind to realize health benefits. Michael G. McKee, "Biofeedback: An Overview in the Context of Heart-brain Medicine, *Cleveland Clinic Journal of Medicine* 75, no. 2 (March 2008): S31. Bauer, 96-97.

[91] Tanya I. Edwards, "Biofeedback: A Tool for Transformation." https://my.clevelandclinic.org/ccf/media/files/wellness/fact-sheets/biofeedback.pdf?la=en (accessed October 23, 2017). Frank et al., 86, Bauer, 98.

and behaviors related to their physiology. The goal of biofeedback is with practice clients will learn to self-regulate without the monitoring device.[92]

This intervention is widely used and accepted, and has the potential to improve many symptoms associated with various medical conditions. Though the exact mechanism of intervention is not understood, most who benefit from biofeedback present with conditions triggered by or exacerbated by stress. Biofeedback is commonly used for an individual to learn how to relax muscles or for reducing or eliminating pain.[93] Ongoing research is examining the efficacy of this complementary therapy treatment for conditions such as asthma, Raynaud's disease, irritable bowel syndrome constipation, nausea and vomiting associated with chemotherapy, incontinence, chronic pain, headache, anxiety stress, high blood pressure, stroke, epilepsy and tinnitus.[94]

Investigation for an appropriate practitioner is important. It has been reported that some health care providers are using "electrodiagnostic" devices and calling them "biofeedback" for insurance reimbursement.[95]

Proper instruction and supervision is required. Biofeedback should be used as part of a comprehensive treatment plan, an adjunct to conventional medicine treatment; it does not replace standard medical care.[96] There are relatively few risks to this treatment modality, the instruments do not cause harm nor do they have side effects.

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[92] Frank et al., 86.

[93] "Biofeedback." https://umm.edu/medical/altmed/treatment/biofeedback (accessed April 1, 2017). McKee, S31. O'Mathúna and Larimore, 140.

[94] Bauer, 98. "Biofeedback."

[95] O'Mathúna and Larimore, 142.

[96] Edwards, Bauer, 98.

*Evaluation*

With recognition of the limitations listed below, a faith community nurse would be able to support this complementary medicine therapy. Biofeedback is an intervention aimed at helping individuals take responsibility for their cognitive, physiological, and emotional well-being. Additionally, this model recognizes the need to see patients as individuals. This intervention may be superior to drug therapy in some cases, as no side effects have been reported.

Biofeedback is not curative, but can be supported both scientifically and theologically if it is to be used for the reasons which may include female urinary incontinence, the reduction of blood pressure, relief of tension and anxiety, treatment of headaches due to tension, treatment of migraine headaches, and relief of back pain. With further research, this generally safe treatment modality may be found to be beneficial for other conditions. A provider should be appropriately credentialed and provide patient education and instruction. No theological concern has been found with this treatment as biofeedback does not require any particular religious belief system.

Hand-mediated Healing Practices- Healing Touch/Therapeutic Touch (HMEH)

Therapeutic touch, known also as healing touch, falls within the category of biofield therapies based on the idea that subtle or nonphysical energies permeate existence and have specific effects on the body-mind of conscious beings. The Indian term *prana* and the Chinese term *ch'i* have been compared to the concepts of *Holy Spirit,* or *spirit.* Although the ontologies may vary, common to the concepts is the idea subtle

energy may be used to stimulate one's own healing process.[97] Practitioners of healing touch, purport their hands transmit energy forces which can improve the energy flow through the receiver. Practitioners believe pain is reduced and relaxation encouraged as they locate and removed energy force disturbances.[98]

Physical touch has played a role in healing throughout history and throughout the world. It is not a foreign concept in Christianity and its roots in healing are captured in the Bible stories.[99] 2Kings 4:32-35, Matthew 20: 29-34, the Letter of James 5:14 are biblical examples.

Touch is characterized as gestural as it relies on active movement, impactful as it depends upon the physical impact of one body with another, and reciprocal as to touch another is to be touched by the other.[100] Believed the first sense to become functional, the sense of touch begins at about eight weeks gestation, developing from reflexive to intentional behavior throughout utero development, and it is the first sensation at the time of birth.[101] Mothers use touch to sooth their children, and skin to skin parent-child contact, and modes of massage have been found to facilitate weight gain, decrease stress and heart rate, improve sleep, and encourage neurodevelopmental maturation in infants

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[97] Shamini Jain and Paul J. Mills, "Biofield Therapies: Helpful or Full of Hype? A Best Evidence Synthesis," *International Journal of Behavioral Medicine* 17 (2010): 1-2. This theory is reflected in internal movement oriented practices such as yoga, tai-chi, and often noted as part of the experience of meditation and prayer, as well as external practices such as pranic healing and laying on of hands. Kate Jaimet, "Energy at Work," *Canadian Nurse* 108, no. 7 (September 2012): 33, 36 posits that the energy field is composed of physical, mental, emotional, and spiritual aspects that can be balanced by an energy practitioner which promotes well-being.

[98] Bauer, 117.

[99] Drew Leder, and Mitchell W. Krucoff, "The Touch That Heals: The Uses and Meanings of Touch in the Clinical Encounter," *The Journal of Alternative and Complementary Medicine* 14, no. 3 (2008), 321, Helen Wordsworth, "Prayer," in *Foundations of Faith Community Nursing* (Memphis, TN: International Parish Nurse Resource Center, 2014), Unit 1, 8.

[100] Leder, and Krucoff, 323-324.

[101] David J. Linden, *Touch: The Science of Hand, Heart, and Mind* (New York: Viking, 2015): 26, Karen Love and Elia Femia, "Touch Therapy," *Health Progress* (November-December 2014): 29.

and pre-term newborns. While touch is crucial in many clinical encounters, healing touch or comforting touch is distinguished as an intentional expert and skilled expression of compassion which may be uniquely incorporated in a variety of treatments, including complementary healing practices, in ways not possible with other senses.[102]

Physiologically, caring touch initiates the brain's release of oxytocin and engagement in the limbic system. This response then stimulates the body's autonomic, endocrine and immune systems. The body's immune system, improved circulation, reduction in muscle cramping and temporary relief of pain can result from the boost in lymph flow. The physiological response can produce emotional responses such as feelings of being cared for, emotional closeness and connection, trust, relaxation, and calm.[103]

*Evaluation*

Hand mediated therapies may be supported by the faith community nurse with some caution. Although a variety of biofield-based practices have been practiced for thousands of years throughout a variety of cultures for the purposes of healing physical and mental disorders, these complementary modalities remain controversial and scientific evaluation is in early stages, but extant. A systematic, non-meta-analysis review of 66 clinical studies of a variety of biofield therapies in different populations found proximally practices techniques showed strong evidence for decreasing pain intensity in pain populations, moderate evidence for reducing pain in hospitalized populations, moderate evidence in reducing pain in cancer populations. Biofield therapies used to reduce pain

[102] Leder, and Krucoff, 323-325, Love and Femia, 29.
[103] Love and Femia, 29.

intensity in patients with pain appeared to provide consistent efficacy over placebo. There was also moderate evidence for biofield therapies to reduce negative behaviors associated with dementia and moderate evidence for decreasing anxiety in hospitalized populations.[104] Although anecdotal evidence suggests healing touch is effective for treating stress-related problems, allergies, heart conditions, high blood pressure, scientific inquiry is required to formalize these conclusions of efficacy.[105]

Healing touch requires discernment on the part of the patient.[106] Some persons perceive health benefits from healing touch, beyond the benefits of relaxation, however, these benefits are not substantiated. While research noted limited effects to no effects of therapy, there seems to be no physical risk in the use of touch therapies. However, in some cases, healing touch may be combined with deeply held religious beliefs and practices.[107]

Christians should spend time with those who are ill, praying for them, comforting them, massaging them and laying on of hands, but the practice should be connected

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[104] Jain and Mills, "12-13, Love and Femia, 30. Recognizing that research methodologies to measure the nuance of touch are insufficient, they purport comforting touch is beneficial for those with dementia as the neural systems underlying emotional processing function after cognitive decline. Those with dementia can also find comprehension of verbal communication exhausting. A 2013 US Administration on Aging funded project found aides reported 50%-70% of their clients with dementia experienced increased happiness, calm, and sleep when touch techniques were used. Laimet, 35, in 2010, *Holistic Nursing Practice* published a review of studies from 1980 to 2008 on the effect of energy-based modalities on pain, and the reviews were mixed. 2008 Cochrane Collaboration review of 24 controlled studies found touch therapies may have a modest effect in pain relief, however due to inadequate data effects of touch therapies could not be defined.

[105] Bauer, 124, Laimet, 35, some attribute the effects to a placebo effect .

[106] Leder, and Krucoff, 326.

[107] Laimet, 33, 35. As the existence of human energy field with material and spiritual dimensions has eluded scientific measurement, energy medicine has not garnered widespread recognition. For instance, Canada's regulatory boards take the position that energy-based modalities are not considered nursing practice.

directly to Jesus Christ and his power, not hand mediated energy healing or other therapy tied with Eastern mystical beliefs or life energy practices.[108]

## Prayer

The integration of faith and health is a primary focus of faith community nursing, and prayer can be one way to provide spiritual care. Prayer and spiritually, components of faith, can be difficult to discuss as the terms are used imprecisely and interchangeably. Spirituality is not connected to a belief pattern; it is shaped through interaction with one's self, others, and the development of a personal value system. Spirituality provides context to life. Whether meditative, colloquial, petitionary or rote, Christian prayer is communication with the triune God[109] and a constituent of Christian spirituality and faith development. Prayer may also be described as the process of linking the outward personal self with the inward divine spirit.[110] Prayer may be used by an individual for their own health concerns,[111] or for the concerns of others.

The Christian nurse has Scriptural support for prayer. Paul implores the Thessalonians (1Thess 5:17), "Pray without ceasing." Matthew (7:7) encourages "Ask and it will be given to you; seek and you will find; knock and the door will be opened to

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[108] O'Mathúna and Larimore, 263.

[109] Bauer, 112, Mary T. Sweat, "Why is Prayer Important?" *Journal of Christian Nursing* 30, no. 3 (July-September, 2013): 182. Annette Langdon, "Learning to Pray," *Parish Nursing: Development, Education, and Administration,* eds Phyllis Ann Solari-Twadell and Mary Ann McDermott (St. Louis: Elsevier Mosby, 2006): 156

[110] Beth Hubbartt, and Donald D. Kautz, "Prayer at the Bedside," *international Journal for Human Caring* 16, no. 1 (2012): 43. Helen Wordsworth, "Prayer," In *Foundations of Faith Community Nursing,* Unit 1, 2, (Memphis, TN: International Parish Nurse Resource Center, 2014).

[111] The results of a 1998 national survey estimated that one third of adults used prayer for health concerns, and users reported high levels of perceived helpfulness. Most did not discuss prayers with their physicians. Anne M. McCaffrey, David M. Eisenberg, Anna T. R. Roger B. Davis, and Russell S. Phillips, "Prayer for Health Concerns: Results of a National Survey on the Prevalence and Patterns of Use, "*Achieves of Internal Medicine* 164 (April 26, 2004): 858.

you." James (5:16) reassures "Therefore, confess your sins to one another and pray for one another, that you may be healed. The fervent prayer of a righteous person is very powerful."[112] The conversation with God, which involves both talking and listening, may take place in a variety of ways for instance speech, song, thought, dance, instrumentation, art.[113]

*Evaluation*

Appropriate prayer is a modality which can be supported by faith community nurses according based on the considerations of this praxis. Prayer for personal comfort and endurance is integral to Christian spirituality and health.[114] Additionally, praying is an opportunity for a caring moment, the essence of nursing.[115]

Evidence for the effectiveness of prayer is inadequate; study of prayer within health care settings is a new phenomenon. However, in spite of the fact studies on prayer have presented mixed results, there is reason to believe that religious affiliation and practices are associated with better and longer life. Some research seems to demonstrate those who consider themselves spiritual are better able to cope with daily stress in one's

[112] Scripture citations are from Senior, Donald, ed. *The Catholic Study Bible: New American Bible*. (New York: Oxford University Press, 1990).

[113] Langdon, 156.

[114] O'Mathúna and Larimore, 244. The American Nurses Association *Code of Ethics* and the International Council of Nurses *Code of Ethics* encourage nurses to provide spiritual care, including prayer if described by the patient. Nursing outcomes may be improved by supporting patient and family's need for prayer. Hubbartt, and Kautz, 43.

[115] Hubbartt, and Kautz, 43,46. The notion of caring as the essence of nursing is proposed by theorist Jean Watson. See chapter 4, page 64-65 for a brief overview. Prayer is a personal experience, therefore it is important prayer be desired by the client, patient preferences are heeded, and the prayer not construed as coercive.

life and heal from illness or addition, and a small body of literature links immune function to spiritual well-being.[116]

Prayer may be a therapeutic beneficial for those with whom the faith community nurse ministers, whether the venue is an individual interaction or a group setting. Anecdotally, the descriptions of the experience of prayer include peace, comfort, healing, love, affirming, cleansing, nurturing, powerful, calmness, acceptance, gratitude and hope.[117]

Inconclusive results from prayer research should not be viewed as evidence against the power of prayer. God never promised an answer to every prayer immediately or in the affirmative. The belief in prayer is rooted in Scripture which teaches prayer. Prayer is based on our theological beliefs not solely scientific research.[118]

To ensure theological fidelity, it is incumbent on the faith community nurse to ensure prayer fundamentally reflects the Christian view of reality, people, and God. The faith community nurse must ensure avoidance of exposure to occult activities labeled as prayer, critique may be necessary to ensure the content is not outside Christian understanding.[119]

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[116] Bauer,112. Researchers have had difficulty defining spiritual practices as they have different meanings to different people. Hubbartt, and Kautz, 43 report studies suggest a correlation between prayer and health. Cheryl Patton, "Surprised by Prayer," *Journal of Christian Nursing* 33, no.4 (October-December 2016): 252 noted prayer as a potential to promote mental health, and suggests prayers as an effective adjunct to healthcare. McCaffrey et al., 858 report although no therapeutic efficacy of prayer is proven, associations between spiritual beliefs and better health outcomes have been made.

[117] Langdon155-156 , Patton, 252. Ping Lei Chui, Khatijah Lim Abdullah, Li Ping Wong, and Nur Aishah Taib, "Prayer-for-health and Complementary Alternative Medicine Use Among Malaysian Breast Cancer Patients During Chemotherapy, *Biomed Central Complementary Alternative Medicine* 14 (October 30, 2014) concluded that many patients undergoing chemotherapy for breast cancer perceived the use of mind-body practices, which included prayer, was beneficial, and the authors suggested mind-body practice be recommended as supportive therapy.

[118] O'Mathúna and Larimore, 244.

[119] Ibid., 101.

## Reflexology

Reflexology is an ancient practice in which differing amounts of pressure are applied to specific points on an individual's hands, feet, or ears. The practice is based on the theory that these points match certain other parts of the body,[120] organs, and systems.[121] The *Yellow Emperor's Classic of Internal Medicine*, written circa 1,000BC, featured a chapter on "Examining Foot Method." The father of reflexology in the United States, William H. Fitzgerald (1917) found that the application of pressure to a zone corresponding to the location of an injury could serve as relief of pain during minor surgeries. Supporters of this modality believe that pressure to the areas affects the organs and benefits the person's health, and reflexology helps facilitate a deep state of relaxation, calm the emotions, and produce a serene mind.[122]

Proponents of reflexology suggest several possibilities on the way in which the intervention might work. First, reflexology works with the central nervous system. This builds on the recognition there is a neurological relationship between skin and the internal organs, and pressure sends a calming message from the peripheral nerves to the central nervous system to adjust the tension level. The second theoretical framework is that reflexology reduces pain by reducing stress and improving mood, building on the gate theory of pain suggesting that pain is a subjective experience created by one's brain. A third theory is that reflexology keeps the body's "vital energy" flowing. This theory

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[120] "Reflexology." https://nccih.nih.gov/health/reflexology (accessed October 24, 2017). Brent A. Bauer, "What is Reflexology? Can it Relieve Stress?" https://mayoclinic.org/healthy-lifestyle/consumer-health/expert-answers/what-is-reflexology/faq-20058139 (accessed October 24, 2017).

[121] Bauer.

[122] "What is the History of Reflexology?" http://twin-cities.umn.edu/ (accessed October 24, 2017).

purports a congestion of "vital energy" develops when stress is not addressed, and reflexology keeps the energy flowing. A fourth theory is the zone theory. This theory reasons the body is divided into ten vertical zones, each corresponds to fingers and toes, and all organs and muscles can be accessed via a point on one's feet or hands.[123]

Evidence varies with respect to the effects of reflexology. Some claim reflexology can treat a wide variety of medical conditions such as asthma, diabetes, and cancer, but these claims are not substantiated by scientific research.[124] Others report relaxation and healing is produced in the body area associated with the reflexology point, but this has not been proven. In one study funded by the National Cancer Institute it was found that women with advanced breast cancer showed improvement in a few symptoms such as shortness of breath, but not others.[125] Other studies by the National Cancer Institutes and National Institutes of Health indicate reflexology may reduce pain, and psychological symptoms such as anxiety and depression.[126] Municipalities and companies have employed reflexologists since the early 1990's and several studies show a reduction in sick leave and absenteeism and employees have reported complete or partial improvement in conditions for which they tried reflexology.[127]

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[123] Ibid.
[124]. Bauer.
[125] "Reflexology." https://nccih.nih.gov/health/reflexology (accessed October 24, 2017).
[126] Bauer.
[127] "What is the History of Reflexology?"

No side effects have been found with this therapeutic intervention. With the exception of discomfort caused by vigorous pressure, this treatment modality was found to be safe, even for the most fragile clients.[128]

Reflexology can be offered within the curriculum of workshops and school, and a beginning level reflexology course includes 15-30 hours of lecture, demonstration, and hands-on practice. The American Reflexology Certification Board required 110 hours in educational modules with accredited instructors, an additional 100 hours of hands-on supervision, passing of a written and practical examination, and submission of 90 documentations of case studies. A code of conduct and standards of care are associated with the national certification. North Dakota and Tennessee license reflexologists and Washington requires reflexologists to become certified with the Department of Health.[129]

*Evaluation*

While massage of feet may feel good, and while it may help with relaxation,[130] limitations of reflexology must be recognized. Caution needs to be exercised as some practitioners claim to diagnose certain illnesses based on the condition of the soles of a person's feet, or those that espouse manipulation of life energy.[131]

This generally safe intervention may be supported by the faith community nurse as a mechanism to facilitate relaxation or alleviate stress. However, no further

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[128] "Reflexology."
[129] "What is the History of Reflexology?"
[130] Bauer, 136. O'Mathúna and Larimore, 252.
[131] Ibid.

expectations for this therapy should be considered at this time, and it should not be used for diagnosis or in lieu of conventional therapeutic practices. Practitioners can be accredited reflexologists, however reflexology is also offered within the disciplines of chiropractic, physical therapy, and massage therapy.

## Reiki

Reiki is an energy-based[132] Japanese modality which involves a practitioner placing his/her hands on or near a person receiving treatment. The intent is to transmit ki, believed to be life-force energy.[133] Reiki is not considered to be a unique religion and used by people of many faith traditions, yet aspects of religion are found in the practice. For instance, Reiki is often described as "spiritual" healing as compared to medical procedures utilizing physical methods for healing. Terminology in the practice of Reiki includes references to God, the Goddess, the "divine healing power," and the "divine mind." Ceremonies in which practitioners receive "attunements" are considered to be "sacred ceremonies." Finally, Reiki is described as a "way of living."[134]

Some project Reiki as clearly antithetical to biblical Christianity;[135] the practice of Reiki involves communication with spirits during attunements and healing sessions.

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[132] For further explanation of energy medicine see the explanation of biofield therapies found in hand medicated therapies, pg. 36.

[133] Laimet, 36.

[134] United States Conference of Catholic Bishops, Committee on Doctrine. *Guidelines for Evaluating Reiki as an Alternative Therapy*. Washington DC: United States Conference of Catholic Bishops, March 25, 2009, #5.

[135] O'Mathúna and Larimore, 255. Leviticus 19:26, 32; Galatians 5:20, and Revelation 21:8 are examples cited for this statement.

Contacting spirits is denounced in the Bible as sorcery, mediumship, and Spiritism, and contacting spirit guides is dangerous spiritually, physically, and emotionally.[136]

For Christians, access to divine healing is by prayer to Christ, and Reiki is not prayer, but a technique passed down through attunement. Although some Reiki practitioners add a prayer to Christ, this does not change the essential nature of Reiki and cannot be identified with what Christians call healing by divine grace.[137]

*Evaluation*

Based on the paradigm presented in this thesis-project, Reiki should have limited support by faith community nurses. There are some anecdotal findings in which individuals report having recovered or improved after receiving a Reiki therapy, however few comprehensive studies have been published. Although some small studies found Reiki produced relaxation and relieved anxiety, no control groups were associated with the studies.[138]

Some practitioners conceptualize Reiki as solely a natural means of healing. This view requires, then, that standards of natural science be applied. Reiki has not been accepted as an effective therapy within scientific communities, and scientific data supporting the potential mechanism of how and why Reiki would work does not exit. The "universal life energy" on which the practice of Reiki is based, is unknown to natural

[136] O'Mathúna and Larimore, 255.
[137] United States Conference of Catholic Bishops,Committee on Doctrine, #8.
[138] O'Mathúna and Larimore, 255.

science, at this time. If Reiki does not have scientific underpinnings, then the justification for Reiki must be found in something other than science.[139]

Promotion of relaxation and feeling of well-being may be the limited benefit of Reiki. Although Reiki has supporters, the practice has not been well-researched and there is little scientific evidence that is can treat any specific condition.[140] Considered medically safe, it should not be used to replace conventional care nor to postpone seeing a health care provider about a medical condition.[141]

Reiki allows a compassionate connection through touch and presence between provider and recipient with the intent to help or heal, and healing touch practices pervade nursing history.[142] However, as other relaxation techniques may be as beneficial as Reiki, it may be more appropriate for Christian, and more specifically Catholic consumers to use modalities that would not have the potential to confuse one's spirituality. Christians believe that man is the union of body and soul. The soul is not an energy force, and energy used as part of the body's operations is material in nature, not spiritual.[143]

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[139] United States Conference of Catholic Bishops, Committee on Doctrine, #7.

[140] Bauer, 127. William Lee Rand, "A Response to the Bishops' Statement of Reiki." http://www.reiki.org/reikinews/responsebishopsstatement.html (accessed January 22, 2015) reports a number of preliminary reputable scientific studies that provide evidence that Reiki is therapeutic. The limited support for this practice may change as more validated evidence becomes available.

[141] "Reiki: What you Need to Know." https://nccih.nih.gov/health/reiki/introduction.htm (accessed April 29, 2015)

[142] Anne Vitale, "An integrative Review of Reiki Touch Therapy Research, *Holistic Nursing Practice* 21, no. 4 (July/August 2007): 178. Vitale cites frameworks for caring-healing modalities have been conceptualized from Florence Nightingale to the American Holistic Nurses Association.

[143] Susan Brinkman, "Reiki and Healing Touch," *Catholic Culture*. http://www.catholicculture.org/culture/library/view.cfm?recnum=8756 (accessed August 21, 2014)

## Tai Chi

When learned correctly and practiced regularly, Tai chi appears to be a positive form of exercise[144] and may have benefits as a potential complementary therapy. This noncompetitive, self-paced gentle exercise may serve as an effective alternative to conventional exercise programs, or serve as an opening to more rigorous activity in frail or deconditioned patients.[145]

Tai chi may be done as an individual, or it may be done in a group setting, and it is an inexpensive modality as it requires no special equipment. With the exception of the need for a small space, Tai chi may be done almost anywhere, in or out of doors.

Although generally considered a safe exercise modality, warnings for Tai chi participation do exist. This low impact exercise, as with any exercise, may lead one to experience sore muscles or sprains if the practice is overdone. If one has a medical condition, or has not participated in exercise for an extended period of time, one's heath care provided should be consulted before beginning tai chi. Practitioners suggest that certain poses should be adapted or avoided if one is pregnant, has a hernia, joint problems, back pain, fractures, or severe osteroporosis.[146]

There are important considerations regarding Tai chi instructors, training, and experience. To be an instructor, an experienced student of Tai chi must obtain a master teacher's approval, however, there are no training standards, and training programs vary. It should also be noted that instructors are not licensed, and practice is not regulated by

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[144] Bauer, 114.

[145] Gloria Y. Yeh, Chenchen Wang, Peter M. Wayne, and Russell S. Phillips, "The Effect of Tai Chi Exercise on Blood Pressure: A Systematic Review," *Preventive Cardiology* 11, no 2 (Spring 2008).

[146] O'Mathúna and Larimore, 259. "Tai Chi: An Introduction." https://nccih.nih.gov/health/taichi/introduction.htm. (accessed April 29, 2015). "Tai Chi: A Gentle Way to Fight Stress." http:///ww.mayoclinic.org/healthy-lifestyle/stress-management/in-depts/tai-chi/art-20045184/ (accessed April 22, 2017).

state or federal governmental agencies.[147] Practitioners who are seriously committed to Eastern religions may teach adherence to the Eastern religious belief is necessary to experience benefits.

Tai chi studies have been conducted and examined its used in a variety of settings. Studies include the use of Tai chi as an intervention for fall prevention and cardiovascular fitness, its potential for improving functional capacity in breast cancer patients, effects on fibromyalgia symptoms, and the quality of life in people with HIV infection, to name a few. For instance, one systematic review of literature suggested that Tai chi may have beneficial effects on blood pressure effective as other life style approaches and may play a role in primary prevention.[148] Another study concluded that tai chi training improves functional balance which is predictive of subsequent reductions in fall frequency in persons aged 70 years or more over a six month period.[149]

However, the studies have generally been small, had design variations and limitations, and have generally been performed on healthy individuals which may limit their conclusions. Therefore, additional research is needed before tai chi can be conclusively recommended as an effective therapy.[150] Future prospective research with carefully chosen and defined populations and validated Tai chi study interventions are

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[147] "Tai Chi: An Introduction." https://nccih.nih.gov/health/taichi/introduction.htm (accessed April 29, 2015).

[148] Yeh et al.

[149] Fuzhong Li, Peter Harmer, K. John Fisher, and Edward Mcauley, "Tai Chi: Improving Functional Balance and Predicting Subsequent Falls in Older Persons, "*Medicine & Science in Sports & Exercise* 36, no. 12 (2004): 2050.

[150] O'Mathúna and Larimore, 259. "Tai Chi: An Introduction." https://nccih.nih.gov/health/taichi/introduction.htm (accessed April 29, 2015).

necessary so that meaningful comparisons across studies and practical inferences can be made.[151]

*Evaluation*

Tai chi meets the criteria of this thesis-project for support of the faith community nurse if the following conditions are met. Appropriate purposes for this mind-body modality include reducing stress, balance improvement, increasing flexibility, and as a low impact exercise. This evidence-based practice is endorsed by the Agency on Agency for fall prevention. Studies suggest Tai chi may also be beneficial as an adjunct in the management of high blood pressure, depression, joint pain, fibromyalgia, and poor sleep. Although specific medical exceptions exist, Tai chi is generally safe when learned correctly and practiced regularly as it is self-paced, slow, and gentle.[152]

Faith community nurse support requires the utilization of an appropriate provider, and the appropriate style. Originally developed for self-defense, as a basic exercise or relaxation program there seem to be no spiritual contraindications to participation[153] in Tai chi as long as eastern philosophical principles contrary to Christianity are not imposed in the session.

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[151] Yeh, et al.

[152] Bauer, 114, "Tai Chi: What Science Says." www.nccih.nih.gov/hea;th/providers/digest/taichi-science (accessed April 10, 2017), "Tai Chi Chic Improves Sleep Quality in Older Adults." www.nccih.nih.gov/research/resulted/spotlight/011109.htm.www.nccih.nih.gov/research/results/spotlight/011109.htm (accessed April 10, 2017, Yeh et al.,

[153] Holy Name of Jesus Church in Hartsburg, PA (www.holynameofjesus.com/parish/organizations/taichi.html) and Pax Christi Catholic Communion of Minneapolis and St. Paul, MN (www.paxchristi.com/contentpages/29465/6d0f22d8-755f-4384-981a-08a362e32645/) are examples of Roman Catholic Churches which offer Tai chi within the faith community.

## Yoga

Yoga, a system of movement (*asanas*) and breathing exercises (*pranayama*) meant to foster mind-body connections, has gained popularity in the United States in the last century, although practiced for thousands of years in India. Yoga classes teach the art of breathing, medication, and posture, and are found in a variety of locations from health clubs to community education venues.

### *Evaluation*

Yoga is a modality that falls within the possibility of support by faith community nurses. Yoga has been found to have mental and physical benefits for people of all ages, including seniors.

As with all of the modalities explored, support requires congruence of goals. Evidence supports Yoga as appropriate for the purposes of decreasing muscular tension and building flexibility and strength, building bone strength with weight-bearing postures, and improving balance. Building muscle strength and feeling stronger can help dealing better with daily self-care activities, reduce stress, and improve sleep.[154] Studies suggest that carefully adapted yoga poses may help to reduce pain an improve function,

[154] "Pill-free Way to Reduce Pain and Improve Balance and Flexibility," *Harvard Health Letter* (March 2014). Bauer, 115. Irene Belle Skowronek, Lara Handler, "Clinical Inquires: Can Yoga Reduce Symptoms of Anxiety and Depression?" *The Journal of Family Practice* 63, no.7 July 2014) 398-400 report across three systematic reviews of yoga for depression, anxiety, and stress, yoga produced overall reductions in symptoms between 12% and 76% with an average of 39% net reduction across measures. Yoga was found to be recommended as an effective adjunctive treatment to decrease severity of depression symptoms, a potential for the treatment of post-traumatic stress disorder and as an intervention for workers compensation conditions including occupational stress, major depressive disorders, and other mental disorders.

such as the ability to walk and move in those with chronic low-back pain.[155] The National Institutes for Health has identified Yoga can help slow breathing, lower blood pressure, alter brain waves, and assist in heart efficiency.[156] Additionally, Yoga practices may be associated with medication reduction in people with mild to moderate asthma, decrease symptoms of depression, and lower blood pressure, however, this Yoga should be used as an adjunct to the medical plan in consultation with a medical care provider.

Although Yoga produces no reported harmful side effects,[157] overall safety must be addressed on an individual basis. As articles suggest there are risks for those with osteoporosis or other fracture risk factors,[158] finding the appropriate fitness level the type of Yoga is essential in participation consideration Different schools of Yoga exist, some of which are extremely taxing and vigorous and should be performed only by fit and healthy individuals, while others are gentle, accessible to anyone.[159] High blood pressure, glaucoma, sciatica, and pregnancy may contraindicate certain yoga poses.[160]

Finding the appropriate Yoga instructor and selecting a suitable program may be a challenge to the consumer due to the variability of yoga practices and lack of universal and standard credentialing of instructors.[161] The International Association of Yoga Therapists, founded in 1989 to define Yoga therapy and organize practitioners using Yoga to treat health conditions published, suggested 800 hours of study. However,

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[155] *Yoga for Health.* https://nccih.nih.gov/health/yoga/introduction.htm (accessed April 29, 2015). Genevieve Verrastro, "Yoga as Therapy: When is it Helpful?" *The Journal of Family Practice* 63, no. 9 (September 2014), E1.

[156] Bauer, 115.

[157] Skowronek, Mounsey, and Handler, 398, *Yoga for Health.*Yoga is generally low-impact and safe for healthy people when practiced appropriately under the guidance of well-trained instructor.

[158] Verrastro, "E6.

[159] Ibid., E2.

[160] *Yoga for Health.*

[161] Verrastro, E2.

membership does not require certification or credentialing, some types of Yoga have their own credentialing, and many experienced and well-respected instructors lack formal credentials. A 200 and 500 hour curriculum covering anatomy, yoga philosophy, and hands on practice is offered through the Yoga Alliance.[162]

The ultimate goal of yoga is to reach complete peacefulness of mind and body, and some styles may pose spiritual threat. In its full form, Yoga combines physical postures, breathing exercises, meditation, and a distinct philosophy, and may require adherence to behavior, diet, and meditation practices[163] which may be contrary to Christian spirituality,[164] and inappropriate for the spiritually vulnerable.

## Summary

A law of physics states for every action, there is an equal and opposite reaction. That is also true with respect to medical therapies, whether conventional or complementary. While some therapies may be supported by objective data, the absence of such data does not mean that the therapy is neutral. A reaction may not yet be able to be measured as there is not equipment sensitive enough to measure the reaction, or there may be a negative reaction. Negative reactions may occur within the physical and/or the spiritual realm.

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[162] Ibid.

[163] Bauer, 115. *Yoga for Health.*

[164] A particular yoga practice may be critiqued against the questions presented in Pontifical Council for Culture for Interreligious Dialogue. J*esus Christ the Bearer of the Water of Life: A Christian reflection on the "New Age."* (February 3, 2003) to determine appropriateness. See Chapter 4, pages 45-46 for list of questions.

Complementary medicine therapies are nonpharmacological interventions which may benefit certain conditions, without the potential side effects of medication. However, complementary modalities are not all equal. The application of this praxis demonstrates it may be used as a guide for decision making; however, all of the complementary therapies had further conditions for consideration. Generally speaking, for the appropriate conditions the modalities of acupuncture, biofeedback, prayer, reflexology, and Tai chi may be supported by a faith community nurse. Yoga and hand-mediated modalities may be appropriate in certain cases. Reiki, while not completely contraindicated, should be supported in limited use based on the potential for spiritual quandary.

# CHAPTER 6

## Conclusion

Throughout history, faith communities have responded to healthcare needs of the community. Biblical stories, the establishment of healthcare institutions, the development of medical school training, and the recent emerging inquiry of *theosomatic* medicine,[1] support the interweaving of religion, spirituality, health and healing.[2] Evolving healthcare challenges, such as escalating health expenditures and underserved populations, provide an opportunity for church to have an increasingly prominent role in health care education, care, and advocacy through ministries of health, healing, and wholeness.[3]

"Health," a word with the same etymology as "whole," is affected by physical, mental, emotional, social, moral, relational, and spiritual factors.[4] The health of each of

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[1] Jeff Levin, *God, Faith, and Health: Exploring the Spirituality-Health Connection* (New York: John Wiley & Sons, 2001), 12-15 defined *theosomatic medicine* as a model or view of the determinants of health based on apparent connections between God, or spirt, and the body. Levin identified seven guiding principles which describe the relationship between religion and spirituality and effects on health. These are 1) Religious affiliation and membership benefit health by promoting healthy behavior and lifestyles, 2) Regular religious fellowship benefits health by offering support that buffers the effects of stress and isolation, 3) Participation in worship and prayer benefits health through the physiological effects of positive emotions, 4) Religious beliefs benefit health by their similarity to health-promoting beliefs and personality styles, 5) Simple faith benefits health by leading to thoughts of hope, optimism, and positive expectation, 6) Mystical experiences benefit health by activating a healing bioenergy or life force or altered state of consciousness, and 7) Absent prayer for others is capable of healing by paranormal means or by divine intervention. Jeff Levin, "From Psychosomatic to Theosomatic: The Role of Spirit in the Next New Paradigm, *Subtle Energies & Energy Medicine,* 9, no. 1: 17. http://journals.sfu.ca/seemj/index.php/seemj/article/viewFile/245/208 (accessed March 30, 2018). Levin proposes psychosomatic (body-mind) paradigm as a transitional gateway to a new medical and scientific understanding which views humans as unity of body, mind, and spirit, theosomatic (God-body) medicine.

[2] Harold G. Koenig, "Religion, Spirituality, and Health: The Research and Clinical Implications," *ISRN Psychiatry* (2012): 1.

[3] Mary Chase-Ziolek, "Reclaiming the Church's Role in Promoting Health: A Practical Framework," *Journal of Christian Nursing* 32, no. 2 (April-June 2015): 101.

[4] Dónal O'Mathúna and Walt Larimore, *Alternative Medicine: The Christian Handbook* (Grand Rapids, MI: Zondervan, 2007), 53. The Joint Commission on Accreditation of Hospitals states patients have specific characteristic and nonclinical needs that can affect the way they view, receive, and participate

us is interconnected to the health of all of us[5] and the church is positioned to address the individual and communal responsibility for health promotion and disease prevention, with particular intention to the care of the client's spirit through faith community nursing. This specialty practice connects the disciplines of science and theology and recognizes health as a dynamic state influenced by the dimensions of body, mind, and spirit.

As the healthcare and associated factors have changed, patient's care needs have become more complicated. For example, immediate access to information, which may or may not be reliable, is a concern. Many conventional treatment options, while offering benefits, also pose possible negative side effects. For instance pain may be addressed pharmacologically; however, side effects may include drowsiness, irregularity, dependence, or even overdose.[6] Anxiety disorders are mental illnesses characterized by excessive anxiety which is defined as a response to an ambiguous sense of present or future threat or danger. They may be treated cautiously with effective medications but other interventions may be engaged to augment the treatment plan. These interventions may include patient education, education, imagery, massage therapy, and biofeedback may help to reduce stress.[7]

A variety of complementary medicine therapies available to the public may offer treatment options. As modalities may be found outside conventional medicine

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in healthcare. Supporting spiritual needs can help patients cope with their illness. Deborah J. Ziebarth and Katora P. Campbell, "A Transitional Care Model: Using Faith Community Nurses," *Journal of Christian Nursing* 33, no. 2 (April-June 2016): 114.

[5] Chase-Ziolek, 106.

[6] "Opioid Prescription Study Sparks Talk of Nondrug Approaches to Chronic Pain," *PTinMotion* (March 2016): 42 cited an article published in the *Annals of Internal Medicine* noting the individuals who survived prescription overdose were able to get additional prescription following the overdose. Studies show a 6.5% rise in overdose deaths from 2013 to 2014 and a 137% increase since 2000.

[7] Debra Walker and Jane Leach, "Anxiety: Etiology, Treatment, and Christian Perspectives," *Journal of Christian Nursing* 31, no. 2 (April-June 2014): 90-91.

recommendations, and proof of efficacy may lack the scientific rigor of other conventional therapies, parishioners may approach a faith community nurse with questions regarding the use of a complementary medicine practice. To offer appropriate ethical guidance, faith community nurses need a process to assess knowledge of complementary medicine therapeutic practices, the evidence base of the efficacy of practices, potential impact on conventional medical treatment, and possible spiritual implications. This thesis project was designed to address the question, "What is the process used by faith community nurses to determine whether to encourage or discourage the use of a complementary medicine practice?"[8]

Using the practical theology model to structure this thesis project, a semi-structured interview tool[9] was developed to guide discussions to describe current process considerations when contemplating specific complementary medicine therapies. After project approval by the Institutional Review Board of Barry University, a convenience sample of twenty faith community nurses participated in a face to face interview.

Although no nurse rejected the potential use of complementary medicine therapies, the level of commitment to complementary modalities as adjunct therapy was mixed. A review of the responses found the nurses consistently reported use of the nursing process when considering a complementary therapy practice. The nurse participants integrated information received from discussion with the individual with other resources ranging from peer reviewed journals to popular resources and personal

[8] The practice of faith community nursing is consultative and not prescriptive; therefore, the faith community nurse assists an individual make an informed decision.

[9] See Appendix F for interview tool. Should this tool be used in a future project, additional questions are suggested. The faith community nurse should be asked what ethical guidelines are used, the length of time in nursing, the level of support perceived by the faith community nurses, and a question as to when the nurses were trained to determine if the time and type of education/formation affected responses.

referrals with respect to the medical impact of the therapies. With respect to spiritual implications for the use of complementary therapies, generally the nurses were not informed of faith tradition declarative statements and often relied on the direction of leadership such as the pastor or church council.

The reasons for the process used by the faith community nurses were contemplated in the interpretive task of this practical theology model. Sociological factors affecting the disciplines of medicine and ministry were considered.

The consistent use of the nursing process may reflect the immersion of nurses in this practice. Throughout educational and formational processes, nursing students learn to assess, plan, implement, and evaluate. Utilization of the nursing process continues to be required by professional nurses.[10]

The deference to leadership for direction may be associated with the historical development of nursing, and the historical understanding of the role of women in society; often a subordinate position. A subset within medicine, nursing has historically been a predominantly female occupation, and not always considered an honorable endeavor. Nurses generally followed the direction set forth by the physician without question, historically a principally male occupation.

At the same time, the church has mirrored society. It is a recent phenomenon for females to work formally within a pastoral care setting in many faith traditions. Governance in some faith communities requires ordination which has been the exclusive domain of males in many faith traditions. Ordination continues to be limited in some

[10] The standards of practice for faith community nursing are set forth in *Faith Community Nursing: Scope and Standards of Practice*, 2nd ed. (Silver Spring, MD: American Nurses Association, 2012) and include the activities of assessment, planning, implementation, and evaluation. See Appendix A for a complete list of standards of faith community nursing practice.

faith traditions such as the Roman Catholic Church. Therefore, the church setting is a second historically predominantly male directed setting affecting the practice of faith community nurses.

Even though faith community nurses work within the context of their faith community, as nurses and ministers with organizational and culture influences, nurses are responsible for their own clinical decision making actions. It is appropriate to collect data from a variety of sources; however, an activity decision on the part of a nurse cannot be abdicated. "Nurses have vested authority, and are accountable and responsible for the quality of their practice."[11]

Having considered the current status of the decision making process of the faith community nurses, and potential factors which influence the decision making process, what ought to be done was addressed in this thesis-project in the normative task. To inform a proposed praxis, professional nursing, theological, and pastoral guidelines were explored. Arguments concerning specific complementary medicine practices were provided.

Synthesizing the nursing process with an adaptation of *Four Topics,* a model for clinical decision making, the final task of this thesis project, the *pragmatic task*, offered a framework to assist faith community nurses provide an ethical response when queried regarding complementary therapies. This praxis engaged the notion of wholistic health and individual care, considerations inherent to the practice of faith community nursing, and considerations intrinsic to ministry. This praxis was generally applied to the

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[11] American Nurses Association, *Code of Ethics for Nurses with Interpretive Statements* (Silver Spring MD: American Nurses Association, 2015), 15. Provision 4 articulates, "Nurses bear primary responsibility for the nursing care that their patients and client receive and are accountable for their own practice."

complementary therapy therapies under consideration, recognizing responses must be made based on considerations of the individual.

Using the praxis, the complementary medicine practices of acupuncture, biofeedback, reflexology, and tai chi were determined to be generally safe. As with all interventions, conventional medicine and complementary alike, qualified providers and appropriate expectations and goals are implied in the support of the therapies.

With some caution, hand mediated practices, known as healing touch or therapeutic touch, may be supported for benefits of relaxation. However, these practices may not be appropriate for vulnerable individuals who are seeking results unsubstantiated by evidence, or with practitioners supporting deeply held religious beliefs and practices.

Yoga should be supported with care. Used as a gentle form of exercise and breathing techniques with appropriate instruction, Yoga may be considered a safe modality. However, spiritual safety is somewhat dependent on the school of Yoga used and the philosophical leanings of the yoga practitioner, as some practices require behavior, diet, and mediation practices which are contrary to Christian spirituality.

When the praxis was applied, Reiki garnered less support than other therapies explored in this project. While Reiki does not seem to cause physical harm, it does not appear to be supported with scientific data. Anecdotally, findings suggest that Reiki may enhance relaxation and the benefits from relaxation. However, other relaxation techniques may be better to avoid spiritual confusion and preserve Christian understanding of healing.

The praxis application was not without its problems. A focal point of Christianity and faith community nursing, Christian prayer, posed some difficulty. Depending on the

goal of prayer, it may or may not be appropriate, according to the proposed praxis. For instance, if the goal is healing, it may be appropriate, however if the goal is expected cure, it may not be appropriate. Scientific inquiry for prayer has produced mixed results. Religious affiliation and practices are associated with better and longer life, yet the effectiveness of Christian prayer is based on belief and not on scientific evidence.[12] As the author of Hebrews (11:1) attests, "Faith is the realization of what is hoped for and evidence of things not seen."[13]

Actions can be a result of tradition rather than science,[14] but good medicine requires sound scientific foundation. Health outcomes require analysis to prove or disprove the complex, dynamic, and higher-order system of medicine approaches.[15] Yet, a one-time analysis is not sufficient. We are reminded that discernment is dynamic, and must remain open to new stages of growth and to the possibility of new decisions.[16] As new techniques of study and investigation are developed, new things are discovered that were formally missed.[17]

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[12] Dónal O'Mathúna and Walt Larimore, 244.

[13] Senior, Donald, ed. *The Catholic Study Bible: New American Bible*. (New York: Oxford University Press, 1990), 363 .

[14] Julie Miller, Denise Drummond Hayes, and Katherine W. Carey, "20 Questions: Evidence-based Practice or Sacred Cow?" *Nursing 2015* 45, no. 8 (August 2015): 55, 46.

[15] Iris R. Bell, Opher Caspi, Gary E. R. Schwartz, Kathryn L. Grant, Tracy W. Gaudet, David Rychener, Victoria Maizes, Andrew Weil, "Integrative Medicine and Systemic Outcomes Research: Issues in the Emergence of a New Model for Primary Health Care," *Achieves Internal Medicine* 162 (January 28, 2002), 139.

[16] Francis, *Amoris Laetitia,* (Vatican City: Libreria Editrice Vaticana, 2016), p. 234, #303.

[17] Neil Theis and Rebecca Wells, "A New Organ that Could Explain the Mysteries of the Human Body," *Science Friday*, NPR (March 30, 3018). The interstitium, a spongy layer of connective tissue that is pervasive through the body has recently been identified due to advances in discovery technique. Formerly the microscope was the gold standard for microanatomy review which relied on slides of tissue removed from the body. However a technique which allowed for microscopic view of live tissue allowed scientists to see reactions that led to the recognition of the interstitium. New hypotheses are posed as this organ may provide answers to the anatomical mechanism for the way in which acupuncture works, and the

Faith community nurses provide wholistic care for those they meet in a therapeutic relationship through presence, active listening, and providing support. While interventions of Western medicine offer many opportunities for health and in some cases cure, at this point, conventional medicine does not offer universal panacea. Other modalities may augment a client's well-being. This thesis project developed a praxis to be used by faith community nurses to help their parishioners navigate decision making that is both practical and ethical.

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meridians of acupuncture may correspond to channels created by interstitium structures. Although not proposed the interview cited, interstitium may also be associated with explanation of reflexology.

# APPENDICES

## Appendix A

## Faith Community Nursing Standards

Faith community nurses, who are registered nurses specializing in faith community nursing are responsible to the following:[706]

Standard 1: The faith community nurse collects comprehensive data pertinent to the health care consumer's wholistic health or situation.

Standard 2: The faith community nurse analyzes the assessment data to determine the diagnosis or issues.

Standard 3: The faith community nurse identifies expected outcomes for a plan individualized to the healthcare consumer or the situation.

Standard 4: The faith community nurse develops a plan that prescribes strategies and alternatives to attain expected outcomes.

Standard 5: The faith community nurse implements the identified plan.

Standard 6: The faith community nurse evaluates progress toward attainment of outcomes.

Standard 7: The faith community nurse practices ethically.

Standard 8: The faith community nurse attains knowledge and competence that reflect current nursing practice.

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[706] *Faith Community Nursing: Scope and Standards of Practice, 2nd ed.,* 19-52.

Standard 9: The faith community nurse integrates evidence and research finding into practice.

Standard 10: The faith community nurse contributes to quality nursing practice.

Standard 11: The faith community nurse communicates effectively in a variety of formats in all areas of practice.

Standard 12: The faith community nurse demonstrates leadership in the professional practice setting and the profession.

Standard 13: The faith community nurse collaborates with the healthcare consumer, family, and others in the conduct of nursing practice.

Standard 14: The faith community nurse evaluates his or her own nursing practice in relation to provisional practice standards and guidelines, relevant statutes, rules, and regulations.

Standard 15: The faith community nurse utilizes resources to plan and provide nursing services that are safe, effective, and financially responsible.

Standard 16: The faith community nurse practices in an environmentally safe and healthy manner.

# Appendix B

## Standards of Professional Performance for Faith Community Nursing

### Standard 7: Ethics[707]

The faith community nurse practices ethically.

Competencies

The faith community nurse:

- Uses Code of Ethics for Nurses with Interpretive Statements (ANA, 2001) to guide practice.
- Delivers care in a manner that preserves and protects the healthcare consumer's autonomy, dignity, rights, and spiritual beliefs and practices.
- Recognizes the centrality of the healthcare consumer and family as core members of any healthcare team.
- Upholds healthcare consumer confidentiality within religious, legal and regulatory parameters.
- Assists healthcare consumers in self-determination and informed decision-making.

[707] *Faith Community Nursing: Scope and Standards of Practice, 2nd ed.,* 35-36.

- Maintains a therapeutic and professional healthcare consumer-nurse relationship within appropriate professional role boundaries.
- Contributes to resolving ethical issues of healthcare consumers, colleagues, community groups, or systems, and other stakeholders.
- Takes appropriate action regarding instances of illegal, unethical, or inappropriate behavior that can endanger or jeopardize the best interests of the healthcare consumer or situation.
- Speaks up to question healthcare practice when necessary for safety and quality improvement.
- Advocates for equitable healthcare consumer care.
- Empowers healthcare consumers in developing skills for self-advocacy in support of their spiritual beliefs and practices.
- Incorporates ethical and moral theories, principles, and models in processes of care planning and delivery. Acknowledges and respects tenets of faith and spiritual belief system of a healthcare consumer.

# Appendix C

## Provisions of the Code of Ethics for Nurses[708]

Provision 1: The nurse practices with compassion and respect for the inherent dignity, worth, and unique attributes of every person.

Provision 2: The nurse's primary commitment is to the patient, whether an individual, family, group, community, or population.

Provision 3: The nurse promotes, advocates for, and protects the rights, health, and safety of the patient.

Provision 4: The nurse has authority, accountability, and responsibility for nursing practice; make decisions; and takes action consistent with the obligation to promote health and to provide optimal care.

Provision 5: The nurse owes the same duties to self as to others, including the responsibility to promote health and safety, preserve wholeness of character and integrity, maintain competence, and continue personal and professional growth.

Provision 6: The nurse, thorough individual and collective effort, establishes, maintains, and improves the ethical environment of the work setting and conditions of employment that are conducive to safe, quality health care.

[708] American Nurses Association, *Code of Ethics for Nurses with Interpretive Statements* (Silver Spring, MD: American Nurses Association, 2015), v.

Provision 7: The nurse, in all roles and settings, advances the profession through research and scholarly inquiry, professional standards development, and the generation of both nursing and health policy.

Provision 8: The nurse collaborates with other health professionals and the public to protect human rights, promote health diplomacy, and reduce health disparities.

Provision 9: The profession of nursing, collectively through its professional organizations, must articulate nursing values, maintain the integrity of the profession, and integrate principles of social justice into nursing and health policy.

Appendix D

Letter of Introduction

Date

8489 Laurel Lakes Blvd

Naples, FL 34119

Dear _____,

I am a Doctor of Ministry Student at Barry University. A thesis-project is required to fulfill the requirements of the program. My project is titled, Faith Community Nursing: Providing Appropriate Clinical/Pastoral Response Regarding Complementary Medicine Therapies. I am writing to request your participation in this study.

This study will include faith community nurses who are retired or actively in practice in a faith community nursing practice. While the hours of the position and whether the position is paid or volunteered will be tracked, this information is neither criteria for inclusion nor exclusion in this study. While it is hoped that this project will contribute to the profession of faith community nursing, no specific benefit to you, for your participation is expected.

I would like the opportunity to interview you for this project and it will take approximately one hour to complete the interview. The interview will be conducted at a place and time which is convenient for you, or via telephone. If neither of these options are amenable to you, I am requesting that you complete a short questionnaire. I will contact you in the near future, to determine your willingness to participate in this study.

Thank you in advance for your consideration of participation in this project.

Sincerely,

Rosanne Rechlin, RN, MSN, CRRN (Principal investigator)

Institution: Barry University, 11300 NE 2nd Ave, Miami Shores, FL 33161

Advisor: Raymond Ward, PhD. 413-374-8544 IRB point of contact: 305-899-3020

Appendix E

Informed Consent Form (Face to Face Interview)

Your participation in a research project is requested. The title of the study is Faith Community Nursing: Providing Appropriate Clinical/Pastoral Response Regarding Complementary Medicine Therapies. The research is being conducted by Rosanne. B. Rechlin, RN, MSN, CRRN, a student in the Philosophy and Theology department at Barry University, and is seeking information that will be useful in the field of faith community nursing. The aim of the research is to determine the processes used by faith community nurses to respond to parishioner inquiries regarding specific complementary therapies. In accordance with this aim, the following procedures will be used: a semi-structured individual face to face interview. We anticipate the number of participants to be 25.

If you decide to participate in this research, you will be asked to do the following: Meet individually with the researcher, for approximately one hour to discuss the decision making process for confirming or refuting a complementary medicine procedure. Your consent to be a research participant is strictly voluntary and should you decline to participate or should you choose to stop at any time during the study, there will be no adverse effects.

There are no known risks to you with involvement in this study.

There are no known benefits to you for participating in this study.

As a research participant, information you provide will be held in confidence to the extent permitted by law. Data will be kept in a locked file in the researcher's office.

Your signed consent form will be kept separate from the data. All data will be destroyed after five years of completion of the project.

If you have any questions or concerns regarding the study or your participation in the study, you may contact me, Rosanne B. Rechlin, at (239) 353-3527, my supervisor Dr. Raymond Ward, PhD. at (413)374-8544, or the Institutional Review Board point of contact, Barbara Cook, at (305)899-3020. If you are satisfied with the information provided and are willing to participate in this research, please signify your consent by signing this consent form.

Voluntary Consent

I acknowledge that I have been informed of the nature and purposes of this experiment by Rosanne B. Rechlin and that I have read and understand the information presented above, and that I have received a copy of this form for my records. I give my voluntary consent to participate in this experiment.

_____ _____

*Signature of Participant* *Date*

_____ _____ _____ _____

*Researcher* *Date* *Witness* *Date*

(Witness signature is required only if research involves pregnant women, children, other vulnerable populations, or if more than minimal risk is present.)

Appendix F

Data Collection Tool

Interview or Questionnaire

1. Denomination of practice _____

   Personal denomination _____

2. Hours per week worked _____ Paid /unpaid _____

3. Basic level of Nursing Preparation _____ Highest level of Nursing Preparation_____

For the purposes of this interview, complementary medicine therapy will be defined as: therapy that is used as an adjunct to an established conventional medical treatment plan

4. What are your personal thoughts/beliefs related to complementary medicine therapies?

5. Have you had any professional courses regarding complementary medicine?

6. For each of the following therapies, would you be likely to endorse (E), not-recommend (NR), unsure (U), or it would depend on the person and situation (D).

Acupuncture _____ Reiki_____

Biofeedback _____ Tai Chi _____

Prayer _____ Healing/Therapeutic Touch _____

Reflexology _____ Yoga _____

7. If you would not recommend one of the therapies, why? Please be specific for each therapy.

8. Have you had a personal experience with any of the above complementary therapies? If so, please identify the specific therapy and describe your experience. Please use additional space as necessary.

9. Does your denomination have any declarative statements regarding complementary medicine? If so, please identify the document / guideline.

10. Does your particular church have any guidelines with respect to complementary medicine therapies?

    If so, please identify the source of the document.

11. What resources, if any, do you use to evaluate complementary medicine therapies?

12. What is your process for determining whether a complementary therapy practice should be supported or rejected?

13. What resources would you use to guide your practice with respect to complementary medicine recommendations?

14. What concerns, if any, do you have in making a recommendation for complementary therapy?

15. Are your concerns for recommending complementary medicine different than making other recommendations?

16. Is there anything that you think would be helpful to you to determine if you would support or discourage a particular complementary medicine therapy?

Appendix G

Raw Data Collection Tabulation

Table 1 Denominations Represented

| **Denomination** | **Denomination of Faith Community Nursing Practice** | **Personal Denomination** |
|---|---|---|
| Anglican | 1 | 1 |
| Congregational Church | 1 | 0 |
| Episcopal | 1 | 1 |
| Lutheran, ELCA | 4 | 3 |
| Lutheran, Missouri Synod | 5 | 3 |
| Lutheran-Episcopal Combined | 1 | 1 |
| Presbyterian Church USA | 3 | 2 |
| Roman Catholic | 4 | 6 |
| United Methodist | 1 | 3 |

Table 2 Length of Time of Faith Community Nursing Practice

| **Time of Practice** | **Number of Participants** |
|---|---|
| 0-6 months | 3 |
| 6-11 months | 0 |
| 1-5 years | 4 |
| 6-10 years | 3 |
| 11-15 years | 9 |
| >15 years | 1 |

Table 3 Hours Worked Per Week

| Hours Worked per Week | FCNs in Paid Position | FCNs in Unpaid Position |
|---|---|---|
| <9 | 1 | 1 |
| 10-20 | 8 | 5 |
| 21-30 | 5 | 0 |
| 31-40 | 1 | 0 |

Table 4 Education Preparation

| | Basic RN Education Preparation | Credentialed | Highest Level of Education |
|---|---|---|---|
| Associates Degree | 4 | 2 | 2 |
| Diploma | 9 | 6 | 3 |
| Baccalaureate | 6 | 3 | 7 |
| Master's Degree | 1 | 1 | 6 |
| Doctoral Degree | 0 | 0 | 2 |

Table 5 Complementary Medicine Therapy Recommendations

| | Endorse | Not Recommend | Unsure | Depend on Situation |
|---|---|---|---|---|
| Acupuncture | 12 | 0 | 1 | 7 |
| Biofeedback | 13 | 1 | 5 | 1 |
| Prayer | 20 | 0 | 0 | 0 |
| Reflexology | 10 | 1 | 8 | 1 |
| Reiki | 6 | 1 | 9 | 4 |
| Tai Chi | 18 | 1 | 1 | 0 |
| Healing Touch | 17 | 1 | 2 | 1 |
| Yoga | 19 | 0 | 0 | 1 |

Table 6

| **Within Scope of Thesis-Project** | **Personal Experience** | **Education Exposure** |
|---|---|---|
| Acupuncture | 13 | 1 |
| Biofeedback | 6 | 0 |
| Prayer | 20 | 20 |
| Reflexology | 3 | 0 |
| Reiki | 5 | 2 |
| Tai Chi | 9 | 2 |
| Healing Touch | 10 | 7 |
| Yoga | 12 | 2 |
| | | |
| **Outside Scope of Thesis-Project** | | |
| Aroma Therapy | | |
| Chiropractic | | |
| Cranial Therapy | | |
| Guided Imagery/Visualization | | |
| Macrobiotics | | |
| Massage for pain control | | |
| Mindfulness/Meditation | | |
| Music Therapy | | |
| Pet Therapy | | |
| Relaxation therapy | | |
| Tapping | | |

Table 7 Declarative Statements Regarding Complementary Medicine Therapies

| | **Yes** | **No** | **Unsure** |
|---|---|---|---|
| Denomination | 1 | 6 | 14 |
| Particular Church | 6 | 10 | 5 |

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