

THE EMANCIPATORY PRAXIS OF INTEGRAL NURSING:
THE IMPACT OF HUMAN CARING THEORY GUIDED PRACTICE UPON NURSING
QUA NURSING IN AN AMERICAN NURSES CREDENTIALING CENTER MAGNET®
RE-DESIGNATED HEALTHCARE SYSTEM

A Dissertation for NUR 903: Dissertation in Nursing Education and Leadership
Presented to the Faculty of the Nursing Department
The Sage Colleges
School of Health Sciences

In Partial Fulfillment
of the Requirements for the Degree of
Doctorate of Science in Nursing

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May 2013

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In the words of Rumi, "Let the beauty we love be what we do"

All my love, admiration and respect to each of you!

Wendy

Table of Contents

1. Introduction	1
1.1 The Emancipatory Praxis of Integral Nursing.....	5
1.2 Unitary Transformative Paradigm.....	7
1.3 ANCC Magnet® Designated Hospitals and the Nurse’s Work Environment.....	8
1.4 Healing Environments and Independent Therapeutic Nursing Interventions.....	10
1.5 The Theory of Integral Nursing and Integral Health	12
1.6 The Emancipatory Research Paradigm	13
1.7 The Knowledge, Power and Caring Dialect	15
1.8 The Theory of Human Caring	16
1.9 Theory Guided Practice in the Clinical Magnet® Environment.....	19
1.10 Statement of the Problem	21
1.11 Purpose	22
1.12 Background	22
1.13 Significance of the Study.....	23
1.14 Research Questions.....	24
1.15 Summary	24
2. Review of the Literature	26
2.1 Emancipatory Praxis Research	27
2.2 Emancipatory Knowledge Development.....	34
2.3 Critical Feminist Social Theory	40
2.4 Theories of Human Caring and Integral Nursing.....	45
2.5 The ANCC Magnet® Designated Hospital Environment and Control Over Nursing Practice.....	53

2.6 Summary and Gaps in the Literature	57
3. Methodology	61
3.1 Research Design	62
3.2 Specific use of the Research Method.....	63
3.3 Construct Validity, Trustworthiness and Rigor	64
3.4 Participant Selection	68
3.5 Method of Data Collection.....	69
3.6 Role of the Researcher.....	72
3.7 Limitations and Bias	73
3.8 Data Analysis.....	74
4. Research Findings.....	77
4.1 The Participants	78
4.2 The Integral Nursing Questionnaire.....	79
4.3 Research Questions.....	83
Research Question 1:.....	83
Research Question 2:.....	94
Research Question 3:.....	97
Research Question 4:.....	99
5. Discussion of Findings	105
References.....	131
Appendices.....	154
Appendix A: Sparber’s Analysis of State Boards of Nursing Position on Complementary Therapies in Nursing	154

Appendix B: Sparber’s Compilation of Complimentary Therapies in Nursing	156
Appendix C: Office of the Professions New York State Education Department’s Nursing Guide to Practice: New York State Board of Nursing Statement on Independent Role of the Registered Nurse	158
Appendix D: Philosophical Assumptions of Dossey’s Theory of Integral Nursing.....	160
Appendix E: Watson’s Ten Caritas Processes.....	161
Appendix F: Integral Nursing Questionnaire.....	162
Appendix G: Critical Narrative Inquiry: Three Phases	166
Appendix H: Operational Definitions	169

Table of Figures

Figure 1: The Emancipatory Knowledge Development Model (Chinn & Kramer, 2008)	35
Figure 2: The Theory of Integral Nursing (Dossey, 2008)	50
Figure 3: The Emancipatory Praxis of Integral Nursing Model	109

List of Tables

Table 1: Participant Demographics.....	80
Table 2: Education Related to Nursing Theory in Academic Nursing Program	81
Table 3: Academic Education Related to Watson's Theory of Human Caring	81
Table 4: Holistic Nursing and Complementary-Alternative Modalities (CAM) in Nursing ..	82

Abstract

This qualitative study critically examined nurses' perception of nursing qua nursing in an American Nurses Credentialing Center Magnet[®] re-designated healthcare system in Albany NY. Watson's Theory of Human Caring is used by many Magnet[®] hospitals, including the site for this study, to inform and guide nursing practice. Watson's Theory supports concepts and practices of integral health, holism, caring, healing, and the education and integration of complementary health care modalities as independent therapeutic nursing interventions. This study aimed to understand the nurse's emancipatory experience, comportment and self-agency as she/he participated in a theory guided practice; and illuminate the nurses' acquisition, understanding and utilization of knowledge and power as required for engaging independent therapeutic nursing interventions in the unitary-transformative health paradigm.

Eight nurses from the Oncology Unit self-selected to participate without recidivism from August to October 2012. The study was conducted in two parts: 1) A questionnaire was developed by the researcher to collect demographic and educational data from participants including: age, ethnicity, level of academic education, years of experience in nursing and in specialty, education to nursing theory, including education specifically to Watson's Theory of Human Caring and to holistic nursing and Complementary and Alternative Modalities (CAM), and CAM use in practice and self-care; and 2) Kim's (1999, 2007, 2010) Critical Narrative Inquiry Method was used to collect and analyze narrative data in three phases: 1) descriptive 2) reflective; and 3) critical-emancipatory. Written and audio data from in-person interviews were transcribed and analyzed by the researcher. Data was validated by participants and used to answer four research questions: 1) What are the emancipatory experiences of nurses in a Magnet[®] re-designated healthcare system that promotes Human Caring Theory; 2) What are the

patterns that facilitate nurses' comportment and self-agency to fully embody and practice integral nursing qua nursing in a Magnet® re-designated healthcare system; 3) What are the patterns that create barriers to nurses' comportment and self-agency to fully embody and practice integral nursing qua nursing in a Magnet® re-designated healthcare system; and 4) How does the organization support nurses control over their nursing practice within this one ANCC Magnet® re-designated healthcare system? Findings gleaned from the patterns that occurred most frequently in the narrative data included: 1) Nurses used Human Caring and Integral Nursing theoretical concepts to inform and conduct their practice; even though they reported limited education to the theories. Elements of the theories that manifested in their practice and self-care included: advocating, educating, counseling, creating a caring-healing environment by honoring the patient and family's space and wishes, approaching patients and families non-judgmentally with an open mind and loving kindness, using complementary modalities of humor, prayer, intention, authentic presence, music, imagery, touch, and obtaining complementary therapy, palliative and spiritual care consults for patients; 2) Facilitators to practice included: the support of their manager, colleagues and team members, optimal staffing patterns, resource nurses and competent, self-motivated care technicians and support staff; and 3) Nurses in the study confirmed their Magnet® healthcare system values: a) Supportive and participative nursing management; b) Advanced education by providing tuition reimbursement and flexible scheduling; c) Participation in and use of the most current nursing research in their practice; and d) A strong nursing mentoring culture, where nurses empower each other to provide ethical care and advocate for patients' and nurses' rights. Opportunities for nursing education and leadership include: 1) The need to revise academic and continuing education curricula to adopt integral theory guided practice at all levels; 2) The need for advanced practice nurses to translate

conceptual models into practice and help nurses to articulate the value and power of nursing to impact integral health and healing.

Suggested Keywords: nursing, holistic, integral, human caring, theory guided practice, emancipatory praxis, critical narrative inquiry, ANCC Magnet[®].

Chapter One

1. Introduction

This study critically explored the concept of nursing qua nursing within the context of a professional practice model informed by the Theory of Human Caring (Watson, 1985, 2012) within a Magnet[®] re-designated healthcare system in upstate New York. According to Watson and Ray (1988) nursing qua nursing, is nursing for the sake of nursing itself; as compared to nursing under the direction, control and model of medicine. Nursing cultural values in a Human Caring theory guided practice model, defines nursing qua nursing in an expanded role that centers on humanistic, integral-holistic caring and healing for the unique spirit filled individual (patient and nurse) (Watson, 2012). The American Nurses Association (ANA, 2010a, 2010b) and the American Holistic Nurses Association (ANA & AHNA, 2007) affirm holistic caring as the central construct of nursing practice.

The content of nursing qua nursing was explored using Kim's (1999, 2007, 2010) Critical Narrative Inquiry method to elicit data regarding the concepts and practices of holism, caring, healing, and the education and integration of complementary health care modalities as independent therapeutic nursing interventions (ITNIs) within a Magnet[®] re-designated healthcare system in New York State. Nurses have been called to utilize their full scope of practice by the recent Robert Wood Johnson Foundation/ Institute of Medicine's Future of Nursing report (National Research Council, 2011). This study was aligned with the reports' mandate, in the context of nursing qua nursing, to illuminate the scope and value of acute care hospital nursing beyond biotechnical care, and towards the nurse's role in the promotion of integral health and healing. Generation of emancipatory knowledge may help nurses identify and overcome barriers to role development and practice that fully embodies an integral-holistic metaparadigm.

Embodiment of an integral-holistic nursing metaparadigm is supported by Benner, Kyriakidis and Stannard (2011) and described in their work as nurse comportment.

Comportment is described as:

Style, intents, and manner of acting and interacting, which includes gestures, posture and stance; thoughts and feelings that are fused with physical presence and action: includes one's ways of being with patients and families, such as tone of voice, touch, accessibility, tact and staying open and curious in clinical situations (Benner, Kyriakidis & Stannard, 2011, p. 555).

This study aimed to make visible the nurses experience of comportment and self-agency as a humanistic-integral nurse. It raised participant nurse consciousness through the emancipatory, reflective-dialogic process of critical narrative inquiry (Kim, 1999, 2007, 2010; Chinn, 2000, 2008). The reflective-dialogic, critical narrative process has been found to demystify and bring to light the hegemonic impact of nursing, medicine and managerialism's mores` as they impact the nurses ability to shift from a bio-technical positivist model of care, to an integral-holistic, unitary transformative model of care (Johns, 2004; Watson, 2012; Kim; Chinn & Kramer, 2008).

Narrative as a teaching-learning-inquiry process illuminates contextual discourse and helps one to identify meanings in one's experience (Diekelmann, 2003; Sandelowski, 1991, 1994; Skott, 2001; Swensen & Sims, 2003). It is through the use of narratives that we structure and communicate our experience and memories. Experience and actions in life and professional practice are expressed and understood through the use of narratives (Gadow, 1996; 1999; Ironside, 2006, Benner, Kyriakidis & Stannard, 2011).

This critical narrative inquiry sought to understand the nurse's experience and actions as she/he participated in a theory guided practice. It aimed to learn of nurse's acquisition, understanding and utilization of knowledge and power as required for engaging independent therapeutic nursing interventions (ITNI's) in the caring-healing paradigm. ITNI's include

modalities such as creating an aesthetic healing environment, and using complementary and alternative modalities such as therapeutic massage, Reiki, healing touch, therapeutic touch, guided imagery, aromatherapy, relaxation techniques and music therapy with patient care (Stichler, 2009; Swanson & Wojnar, 2004; Dossey & Keegan, 2009; Gagner-Tjellesen, Yurkovich & Gragert, 2001; Radzyninski, 2007, Carper, 1978). Complementary therapies are historically situated within nursing practice and found in Nightingale's work, which refers to the use of music, prayer and creating a healing environment for the patients' wellbeing (Frisch, 2001; Selanders, 2010; Dossey, 2010; Dossey & Keegan, 2009). With the advent of modern medicine, complementary therapies in nursing have taken second stage to biotechnical modalities and care in the hospital milieu (Frisch; Gaydos, 2001). Theory guided holistic nursing practice brings these metaphysical and ontological, preventative, supportive and restorative therapies back to center stage (Gaydos; Watson, 2012; Dossey, 2008). Sparber (2001) found 47 of 53 State Boards of Nursing permit nurses to practice a range of complementary therapies (New York State being one of the 47 states), and encourages nurses to increase their awareness, education and utilization of this privilege (See Appendix A for Sparber's Analysis of State Boards of Nursing Position on Complementary Therapies in Nursing; and Appendix B for Sparber's Compilation of Complementary Therapies in Nursing).

The independent role of the Registered Nurse is defined by the Office of the Professions New York State Education Department (OP NYSED) (2009) as "Registered Nurses may function independently in providing nursing care in such areas as case finding...health teaching...health counseling...care restorative to life and wellbeing...and care supportive of life and wellbeing" (pp. 36-37). Complementary therapies are listed under care supportive of life and wellbeing and OP NYSED states that nurses may use non pharmacologic nursing modalities

including “chronic pain management through non-pharmacological nursing measures such as ergonomic techniques, relaxation, imagery, therapeutic touch, and rational-emotive therapy (RET)” (p. 37) (See Appendix C for Office of the Professions New York State Education Department’s Nursing Guide to Practice: New York State Board of Nursing Statement on the Independent Role of the Registered Nurse).

Registered nurses function in three roles while providing hospital based nursing care. These include: 1) dependently, under the orders of medical providers, physician assistants and nurse practitioners; 2) independently; and 3) collaboratively (OP NYSED). Multiple factors affect a nurse functioning in her/ his role, including socio-cultural and healthcare system barriers, staffing patterns, acuity and other work demands inherent within the acute care hospital environment (Drenkard, 2008). In a multi-country longitudinal study conducted by Aiken (2008), nurses reported a low quality of care, including early patient discharge, and nurses had difficulty delivering all of the care necessary for the well-being of their patients. Inadequate staffing and lack of educational support were cited as the most frequent reasons for low quality of care and adverse patient outcomes (Aiken; Aiken, Clarke, Sloane, Lake & Cheney, 2008). Magnet[®] designated hospitals demonstrate evidence that supports nursing with empowerment processes in education and leadership (American Nurses Credentialing Center (ANCC), 2008; Drenkard, 2012; McClure & Hinshaw, 2002). The Magnet[®] culture of the institution fosters structural empowerment and supports a professional practice model of care designed to inform nursing quality nursing (ANCC; Drenkard; McClure & Hinshaw).

In this study, structural empowerment and the professional practice model of care were examined in one Magnet[®] re-designated healthcare system in New York State, from the critical narrative perspective of nurses, to learn what facilitators and barriers impact their ability to fully

participate in, and provide theory guided integral-holistic human caring. It focused on the praxis of nursing qua nursing, and evaluated how nurses were practicing to the full extent of their education, training and theoretically guided potential as envisioned by extant nursing scholars, educators and leaders (Watson, 2012; Dossey, 2008; Jarrin, 2011, 2012; Clark, 2003, 2004, 2005, 2010; Chinn, 2008).

1.1 The Emancipatory Praxis of Integral Nursing

The emancipatory praxis of integral nursing aimed to uncover and begin to resolve hidden sociopolitical, ideological and oppressive barriers that may hinder nurses' full democracy, freedom, voice, and ability to integrate holistic caring-healing, theory guided practices within an acute care Magnet[®] re-designated healthcare system. The term integral nursing encompasses the practice of holistic nursing and eclipses it by providing a postmodern view of the profession for what Nightingale originally imagined it could be, for what it is, and what it can be (Dossey, 2008, 2010; Watson, 2010c).

Integral nursing heralds a new language, lens and an evolved, emancipated ideology. Watson (2012) focuses the new lens for nursing in her evolving Theory of Human Caring and Caritas consciousness, curriculum and competencies of Caring Science (CS). Watson (2012) believes nursing can view itself as multi-metaparadigmatic, with multiple patterns of knowing and worldviews that affect one's interpretation of the nursing metaparadigm: human being, health, nurse and the environments (internal and external). This notion is iterated further by the integral nursing works of Dossey (2008), Jarrin (2011, 2012) and Hegvary (n.d.).

The multi-metaparadigmatic view includes concepts of ethical, philosophical, spiritual and metaphysical compartments, in addition to clinical, biophysical, sociopolitical and empirical phenomena. Watson (2012) advises that ethical, philosophical, spiritual and metaphysical

contexts in nursing's Caring Science are worthy of further inquiry for the purpose of knowledge development within the discipline. Quinn, Smith, Ritenbaugh, Swanson and Watson (2003) recommend studies to explore the impact of the healing relationship in holistic nursing. From a nursing education and leadership perspective, the healing relationship can take on the dimension of nurse caring for nurse (or nursing student) and nurse caring for system (or organization and culture); which supports nurse caring for patient.

Nurse educators and leaders are role models and advocates for nurses, whom often translate conceptual language and theoretical constructs for practicing nurses (Lincoln, 2009). The Theory of Human Caring is cited as a frequently used theory by acute care hospital nursing departments as the philosophical and theoretical basis for ANCC Magnet[®] professional practice model development (Watson, 2008a, 2009a, 2010b, 2011b; Clarke, Watson & Brewer, 2009; Drenkard, 2008; Higgins Donius & Fleming, 2003; Birk, 2007; Woodward, 2004; Watson & Foster, 2003; Ryan, 2005; Pipe, 2007, 2008; Bent, Burke, Eckman, Hottmann, McCabe & Williams, 2005). Watson (2008a) cites hundreds of hospitals currently using her theory to inform professional nursing practice around the globe.

The theory is situated in the unitary transformative paradigm (Watson & Smith, 2002a). A paradigm can be seen as a culture, with its own set of values and beliefs. Praxis is "values made visible," thoughtful, theory guided practice of nursing qua nursing (Chinn & Kramer, 2008). Praxis becomes emancipatory when nurses find their voice and power by expressing and operating from an integral-unitary-transformative, values based meta-language. The meta-language of nursing (nurse, person, health and environment) is expressed through the nurses' comportment and self-agency in practice-education-research. The philosophical underpinnings of nursing meta-language influence the nurses' understanding and communication of her or his role

through voice, touch, felt sense, verbal and non-verbal behaviors and intentions. How a nurse ultimately comports and utilizes her or his self-agency is largely influenced by socio-cultural mores and learned behaviors. Exploration of socio-cultural mores upon nurse comportment and self-agency may further identify the values and beliefs that nurses' hold about themselves and their role.

1.2 Unitary Transformative Paradigm

Watson's Theory aligns with the integral-holistic, unitary-transformative paradigm. This paradigm views phenomenon as pluralistic, interrelated and whole, as compared to particularistic and of separate parts in the positivist paradigm. The unitary transformative paradigm is supported by other extant holistic nursing theorists and scholars such as: Quinn (1992), Dossey (2008), Rogers (1970), Paterson and Zderad (1976), Newman (1990, 2002), Parse (2007), Leininger (1991), Davidson, Ray and Turkel (2011), Smith (1994), Cowling (1999), Cowling and Taliaferro (2004), Cowling and Repede (2011), and Jarrin (2011). In this paradigm, phenomena are unitary and self-organized, supportive of individual and cultural diversity, and grounded in a relational ontology of moral-ethical-transpersonal caring, which is central to nursing practice.

Nurses who work in a unitary-transformative paradigm use holistic caring-healing modalities, aligned with the patient's socio-cultural beliefs, values and healthcare goals to provide culturally congruent care within the domain of nursing qua nursing (Leininger & McFarland, 2006; Watson & Ray, 1988; Jarrin, 2011). Chinn and Kramer (2008) and Dossey (2008) discuss the importance of nurses using all patterns of knowing to inform her/him while caring for self and patient/client. Zander (2007) conducted a concept analysis of the historical evolution of ways of knowing in nursing, which she describes as an evolution of the

epistemology and ontology of nursing. Utilizing theoretical constructs in language to explain what it is to be a nurse and what comprises the practice of nursing becomes the salient feature of our age (Chinn, 2000). Watson (2006a) has long advised the nursing profession to understand its value and stand up, speak up and pay attention to the sociopolitical nature of nursing in the healthcare system, lest it be subsumed by the dominant, positivist, bio-technical model and the other rapidly developing healthcare professions.

The dominant positivist, biotechnical model of care is concerned with curing through the use of biologically focused technology and sections patients into individual parts to be cured. In contrast, holism and integral-holistic nursing aim to assist the patient to integrate parts to the whole body-mind-spirit. The patient-nurse relationship is the vehicle for culturally congruent caring and healing to occur (Davidson, Ray & Turkel, 2011; Leininger & McFarland, 2006). It is the nursing care-context-situation through which the integral-holistic-humanistic nurse facilitates the patients healing experience of unity and transformation to new levels of organizing and understanding. This post-positivist, unitary approach fosters humanitarianism, holism and healing. Watson (2011b) regards nurses informed by Caritas (loving kindness) as the “light in institutional darkness.” The nurse who is informed by a Caritas consciousness embodies a heart centered, caring-authentic presence and sets an energetic intention for the highest healing good for all (nurse, patient, family, universe) (Watson, 2012).

1.3 ANCC Magnet[®] Designated Hospitals and the Nurse’s Work Environment

The American Nurses Association (ANA) in collaboration with the ANCC developed and published Magnet[®] standards in 1990 to inspire hospitals to achieve a gold standard of nursing care (ANCC, 2008). The standards are designed to create centers of nursing excellence. In these centers of excellence, shared governance principles are supported with education and a

leadership structure designed to place knowledge and power in the hands and voices of nurses (McClure & Hinshaw, 2002). Longitudinal outcome studies of Magnet[®] hospitals reveal lower patient morbidity and mortality rates, fewer nosocomial infections, higher patient satisfaction scores, higher nurse satisfaction scores, higher nurse recruitment and retention rates, higher levels of nursing education and a more collegial nursing work environment (Scott, Sochalski, & Aiken, 1999; Aiken, Havens & Sloane, 2000; McClure & Hinshaw, 2002; Aiken, Clarke, Sloane, Lake & Cheney, 2008; Clarke & Aiken, 2008; Lundmark, 2008;). Recent studies, however, (Drenkard, 2008; Armstrong & Laschinger, 2006; Brewer, 2006) demonstrate concern for nurses lack of cultural empowerment, involvement in control over nursing practice and decreased ability to care adequately for patients based on excessive workload, and time, staffing and role constraints. These findings sound an alarm for nurses' distress and the negative impact these conditions may have on nurses' health, and her/his desire and motivation to participate in measures to improve empowerment and autonomy; even in Magnet[®] environments.

Magnet[®] hospitals are required to select, utilize and incorporate a conceptual framework to guide professional practice. Watson's Theory of Human Caring has been selected by many healthcare organizations because it resonates with nurses at all levels for what nursing is and can be (Bent, Burke, Eckman, Hottmann, McCabe & Williams, 2005). Beyond selecting a conceptual framework to inform professional practice, the model must be infused into the culture and reflected in practice. It must be taught to nurses and staff, coached, counseled, and supported throughout the organization by nursing leaders in the healthcare system. The practice environment is affected by the quality of nursing education and leadership. Personal and professional nursing leadership skills at all levels influence the practice environment. Transformational leaders in Magnet[®] environments influence care models by fostering nurse

autonomy, application of research in practice, resource stewardship, collaboration and lifelong learning (Drenkard, 2012). A Magnet[®] environment was selected as the sample environment of this study to further explore the relationship of nursing education and leadership to the emancipatory praxis of nurses practicing within a theoretically guided professional practice model.

1.4 Healing Environments and Independent Therapeutic Nursing Interventions

Quinn (2003, 2010) describes evidence of nurse suffering and distress as the result of toxic work environments and unreasonable demands placed upon the time and energy of nurses. She supports the values inherent in a Magnet[®] culture and advises the development of “habitats for healing” where the holistic nursing paradigm flourishes, and nurses are emancipated to create caring-healing environments. Caring-healing is a term coined by Watson to describe the nurses' authentic presence, caring-healing modalities and nursing therapeutics (Watson, 2012). In the caring-healing environment the nurse has control over her/his practice and the knowledge, power and ability to provide holistic independent nursing interventions including: therapeutic touch, Reiki, therapeutic massage, aromatherapy, guided imagery and music therapy.

Quinn (2010) advises that nurses must be given the economic and socio-political support to create adequate time and space for healing relationships to occur. Quinn calls for transformative change in the healthcare system, from the inside out, starting with nurses. She describes the ripple effect of change that starts with self and impacts the complex adaptive human system and environment. Quinn states, “...caring and healing create new patterns of being, becoming and healing out the chaos of the present moment” (p.16). Swanson's (1999) literary meta-analysis of Caring Science supports the nurse's role of caring as it facilitates biogenesis through the creation of caring-healing environments and behaviors. Stressful

environments, lacking in social support and holistic caring, are toxic and harmful to nurses and patients (Halldorsdottir, 1991, 2007; Halldorsdottir & Hamrin, 1997; Quinn; Swanson).

Watson, a board certified advanced practice holistic nurse (AHN-C), describes compelling reasons for nursing and healthcare to return to the caring-healing arts as blueprinted by Nightingale (1859) and envisioned by herself, Quinn (1992, 2003, 2010) in her *Habitats for Healing*, and Dossey (2008) in her *Theory of Integral Nursing*. Quinn and Dossey are also board certified AHNs. Quinn describes the concept of the nurse as both culture and environment. She advises that healing occurs when the nurse embodies a Caritas (loving kindness) consciousness for the intentional therapeutic benefit of one caring with and for the sacred other (nurse with self, nurse-with-patient, nurse-with-family, nurse-with-nurse, etc). Caritas consciousness creates the biogenic energy of caring and healing. In this model, intentional heart centered thought precedes action. This notion is supported by Halldorsdottir's (2007) research that found caring and uncaring behaviors by nurses produced psycho-neuro-immunological changes in patients. Uncaring encounters elicited the stress response, with associated free radicals and cytokines. Caring encounters elicited the relaxation response and was associated with feelings of peace, unity and harmony.

In regards to the concept of caring and healing in nursing science, Watson (2010b) states, "Caring Science and theory guided clinical care, combined with holistic healing practices, is restoring the human spirit and inner healing processes" (p.15). Nurses are challenged by the professions' scholars to more fully understand and articulate to the healthcare system, the value of nursing, for what it is and what it can be, in its full and expanded view. This notion aligns with the Robert Wood Johnson Foundation/ Institute of Medicine's Report on the Future of

Nursing (National Research Council, 2011) that advises nurses to practice within the full scope of their professional abilities for the optimal health of society.

1.5 The Theory of Integral Nursing and Integral Health

Integral Nursing is a grand theory that is defined as:

A comprehensive integral worldview and process that includes holistic theories and other paradigms; holistic nursing is included (embraced) and transcended (goes beyond) this integral process and integral worldview enlarges our holistic understanding of body-mind-spirit connections and our knowing, doing and being to more comprehensive and deeper levels (Dossey, 2008, p. 4).

It incorporates and is informed by holistic nursing, holistic-integrative health theories and worldviews, and by the original works of Nightingale (1859). Healing is at the center of the Theory of Integral Nursing and is surrounded and encompassed by the metaparadigm concepts of nursing: health, nurse, environment and person. Surrounding the central aspect of healing and metaparadigm concepts are the nurses' multiple patterns of knowing by Carper (1978); Silva, Sorrell and Sorrell (1995); Munhall (1993); White (1995); and Chinn and Kramer (2008, 2011); personal, empirics, ethics, sociopolitical and unknowing. The patterns of knowing and unknowing are then interfaced with the All Quadrants, All Levels (AQAL) framework of Wilber (2000). The AQAL framework provides a structure for understanding and positioning one's worldview and context from inner and outer perceptions of experience. It involves subjective (I), objective (It), intersubjective (We) and interobjective (Its) views and levels of evolvment from me, us, all of us, and group, national and global perspectives.

Dossey (2008) advises of the value of this evolved Integral Theory, language and worldview for nursing, and states, "Only an attention to the heart of nursing, for sacred and heart reflect a common meaning, can we generate the vision, courage, and hope required to unite nursing in healing" (p. 43). This vision and grand theory situates nursing as a unique profession,

with an expanded nursing-worldview immersed in holistic human caring and healing. It supports and includes other nursing (and non-nursing) theories and philosophies within the unitary-transformative paradigm. Watson (2002) advises that the benefit of trans-theoretical discourse of extant nursing theories is that it connects us to our past and provides an opening for the unification of personal and professional knowing in the future. This sentiment is echoed in Jarrin's (2011, 2012) work of developing a unifying metatheory and metalanguage for nursing.

Beyond the borders of nursing, Wilber (2000) and Scharmer (2007) discuss integral health and an evolving integral healthcare system where the providers of care partner with patients by using a salutogenic (health-centered) approach. Salutogenesis is a process that empowers, improves and supports holistic-integral human health on physical, mental, emotional, social and spiritual levels (Scharmer). Integral health is human centered, metaparadigmatic and multi-pluralistic. Nurses who use an integral health approach to theory guided practice are partners in health with their patients. They may use caring-healing, health-promoting modalities such as guided imagery, relaxation, therapeutic massage, music, art, aromatherapy, healing touch, therapeutic touch, reflexology and Reiki (Quinn, 2010; Watson, 2010a). These practices may be seen as nice, and good for customer service, but not necessary in the busy dominant biomedical, technical hospital milieu. Watson (2012) recommends scientific inquiry to further understand the impact of integral-holistic theory guided practice. This scientific inquiry helped to further qualify the positive outcomes of utilizing a caring and healing metaparadigm in hospital nursing care.

1.6 The Emancipatory Research Paradigm

Emancipatory praxis research is grounded in the critical theory of Neo-Marxism, with roots to Aristotle's concept of phronesis and Socrates' concept of dialogue. Emancipatory

research seeks to uncover the hidden sociopolitical, ideological and oppressive barriers that hinder ones democracy and freedom (Lather, 1991; Tsang, 2007; Greenwood & Levin, 2008; Fine & Weiss, 2008). Phronesis is practical, context dependent, values-based knowledge that is generated by one's own internal reasoning through a collaborative and collective praxis oriented process. Greenwood and Levin (2008) state this process "involves egalitarian engagement across knowledge systems and diverse experiences" (pp. 67-68). Tsang (2007) describes phronesis as practical wisdom, best gained through a reflective process of shared dialogue with a social group. Praxis is the practical knowledge gained through the collective application and integration of theory and practice. Access to practical knowledge is best accomplished through a Socratic dialogue process (Tsang; Manthey, 2009). Benner, Kyriakidis and Stannard (2011) discuss clinical wisdom as a process of practical reasoning in nursing that requires "...thinking-in-action and reasoning in transition..." (p. 10). According to Benner, Kyriakidis and Stannard, nursing artistry involves "productive, thinking-in-action based on a narrative understanding of a practice situation" (p.10). Situated learning requires active engagement, integration of multiple knowledge bases and experiences, imagination and the ability to develop a sense of salience (Benner, Kyriakidis & Stannard). Praxis is the practical, broad stroke view of integrating multiple ways of knowing, doing and being in a clinical situation.

Emancipatory praxis research is co-generative in nature, with the researcher keenly aware of the ideal of democracy and equality within the research group. It generates knowledge by raising the research participant's consciousness as insight to the facilitators and barriers of freedom and democracy emerge through the dialogical process (Lather, 1996; Chinn, 2008). The desired outcome of emancipatory research is personal and professional transformation as one consciously evolves with one's world. Transformation is accomplished as the invisible becomes

visible to participants through the process of enlightenment. According to Lather (1988; 1996), the development of research as praxis, evolved from Gramsci's (1971) call to intellectuals to develop a "praxis of the present". "Praxis of the present" was originally designed to aide oppressed groups to become more conscious of their situations in the world. Lather (1996) states "through dialogue and reflexivity, design, data and theory emerge, with data being recognized as generated from people in relationships" (p. 72). Emancipatory research, which is from the people and for the people, fits with the research topic of nursing qua nursing, to generate knowledge from and for nurses and nursing.

1.7 The Knowledge, Power and Caring Dialect

Falk-Rafael (1998) describes the phenomenon of ordered caring that reflects the dominant ideologies, values and world view of those in power (i.e. healthcare system administrators, managers and medical providers). The disempowerment of nurses' results in a loss of healthcare advocacy for those served (Falk-Rafael, 1998, 2001; Quinn, 2008; Kagan, Smith, Cowling & Chinn, 2009). Additionally, Falk-Rafael (1998, 2001) describes how nurses practice "assimilated caring" when they acquiesce to dominant ideology, which is in part due to a lack of empowering language for an ideology that is more nurse centric. In a critical narrative analysis of the findings of the 2003 Nurse Manifest study, Kagan et al. (2009) found that nursing practice has become compartmentalized in the biomedical, positivist model. They believe nursing values are undermined by the healthcare delivery and educational systems, by perpetuation of the biomedical, Cartesian, positivist model of care. Kagan et al. call for emancipatory praxis based, philosophically explicit research. They advise nurses to "act out of a forthright attunement to holistic, humanistic and emancipatory values" (p. 76).

Kagan et al. (2009) discuss the need for novel research and curricular methodologies in nursing praxis as it relates to the Nursing Manifest's social justice agenda of changing social structures and behaviors in practice, education and research to be nurse centric. This change in social structures and behaviors aims to eradicate domination, and empowers nurses to concern themselves with their own comportment and self-agency, as a means to fulfill their ethical and moral advocacy role to those in their care. Chinn and Kramer (2008) advise nurses to develop her/his emancipatory knowing by critically investigating the relationship of sociopolitical forces upon one's perception of the world and her/his place in it. This critical narrative inquiry helped participant nurses to better understand how hegemony impacts professional and personal behaviors that may perpetuate oppression and domination by forces that impact them.

It is time for nurses to create a new ideology and language that empowers them at personal and professional levels, as well as in the healthcare system itself. Herein lays the power of praxis, as the intersection between critical emancipatory research, extant nursing theories (ie: the Theory of Human Caring and the Theory of Integral Nursing) and theory guided practice. Emancipatory praxis in this theoretical context reveals the ideological basis for social belief and behavior. Emancipatory praxis aims to raise nurses' consciousness of what theory guided integral-holistic nursing is and can be, so that the nurse can ultimately comport as an empowered agent using her/his own knowledge, power, and voice.

1.8 The Theory of Human Caring

The Theory of Human Caring is based on feminist, holistic, humanitarian, and postmodern ideology, and is informed by the philosophies of Nightingale, Heidegger, Levinas, and Bingen (Watson, 2007). Transpersonal Human Caring utilizes a reflective practice, a caring-healing holistic ontology and places emphasis on the ethical and moral ideals and values of

nursing from Nightingale's blueprint for the profession (1859). Sitzman (2002) states, "The core identity of nursing is a combination of technical tasks, multilevel interaction with the patient, and self-reflection and growth" (p. 3). According to Watson (2002) the central focus of nursing is, "those aspects of nursing that potentiate healing processes and relationships, which affect the one caring and the one cared for" (p. 3).

Watson defines Caring Science (CS) as giving direction toward inquiry into this domain and states:

CS encompasses a humanitarian, human science orientation to human caring processes, phenomena and experiences. CS includes arts and humanities as well as science. A CS perspective is grounded in a relational ontology of being-in-relation, and a world view of the unity and connectedness of All. Transpersonal Caring acknowledges unity of life and connections that move in concentric circles of caring - from individual, to others, to community, to world, to Planet Earth, and to the universe. CS investigations embrace inquiries that are reflective, subjective and interpretative, as well as objective-empirical, and CS inquiry includes ontological, philosophical, ethical, historical inquiry and studies. In addition, CS includes multiple epistemological approaches to inquiry including clinical and empirical, but is open to moving into new areas of inquiry that explore other ways of knowing, ie: aesthetic, poetic, narrative, personal, intuitive, kinesthetic, evolving consciousness, intentionality, metaphysical-spiritual, as well as moral-ethical knowing (Watson, 2012, WCSI.org).

Watson (1990) identifies patriarchy as a barrier to nursing achieving its holistic vision and states, "Caring as a core value cannot be forthcoming until we uncover the broader, more fundamental politic of the male-oriented worldview at work in our lives and the lives of the people we serve" (p.62). Gilligan (1982) discerns gender differences in relation to power and ethics. She describes patriarchal power as serving an ethic of justice, and feminine power as serving an ethic of caring. Nursing is viewed as feminine, with its primary responsibility of caring, it ethically struggles against the dominant patriarchal power of medicine and managerialism. Johns (2004) asserts that nurses continue to demonstrate an internalized sense of subordination to medicine and managerialism. These sentiments are echoed by Clark (2005),

who argues that nursing education and practice must call for a shift towards a partnership social system if it is to fully realize its transpersonal caring-healing paradigm, and manifest its nursing qua nursing values.

The Theory of Human Caring's Caritas Processes (see Appendix E for Watson's Ten Caritas Processes) and the Theory of Integral Nursing (see Appendix D for Philosophical Assumptions of Dossey's Theory of Integral Nursing) situates caring and healing as central foci in nursing. According to Quinn (2009) healing is defined as the emergence of "right relationship" at one or more levels of the body-mind-spirit system. Quinn defines "right relationship" as a process of connection among or between parts of the whole that increase energy, coherence and creativity of the body-mind-spirit system. Within the healing healthcare system and professional practice model, based on the constructs of transpersonal Human Caring, nurses are conscious of and utilize interpersonal dynamics, relationships and modalities that promote health and wellness. Health is promoted through the use of salutogenic, caring-healing nursing therapeutics that are biogenic and create experiences of unity and connection to bio-psycho-social-spiritual oneness with the larger environment or cosmos (Quinn, 2010). This integral-holistic healing approach to caring is in addition to and coexisting with curative technologies. When nurses are informed and guided by integral-holistic theory in their practice, they see and practice nursing in the full character or role of nursing qua nursing.

Integral nurses care and heal with an authentic, conscious presence that acknowledges the patients right and the nurses' deontology to salutogenesis. Evidence exists that nurses are using caring-healing modalities and integral-holistic approaches to care in Magnet[®] designated hospitals (International Caritas Consortium, 2011), however, questions remain regarding: 1) how nurses are educated in nursing theory; 2) if nursing theory is infused into the cultural mores,

language and structures that empower nurses; 3) if nurses have power and control over their independent practice choices; and 4) if nurses can adequately give voice to, facilitate and utilize theoretical concepts in their beliefs, behaviors, language and actions in the healthcare environment. Thomson and Hammer (2007) believe that nurses in Magnet[®] designated acute care settings have difficulty bridging the dominant biomedical model of care to theory guided holistic care.

1.9 Theory Guided Practice in the Clinical Magnet[®] Environment

McClure and Hinshaw (2002) state, “In Magnet[®] hospitals there appears to be some shifting of power- nurses are changing the balance of power- their own sense of value will no longer allow them to accept situations where they do not have a voice” (p. 23). Magnet[®] status boasts a social and professional emancipatory paradigm that seeks to empower nurses through shared decision making structures. However, there is concern that Magnet[®] designation alone is not enough to empower nurses (Armstrong & Laschinger, 2006; Aiken, Havens & Sloane, 2000; Aiken, 2008; Brewer, 2006). Brewer discusses the impact of culture on patient care outcomes and cites a direct correlation between negative healthcare team processes (ie: conflict, inflexibility and shirking of responsibility) with longer length of stays for patients in acute care hospitals. Culture sets the tone for the work environment via social values, mores, beliefs, behaviors and actions, and impacts relationships, communication and the ability to provide optimal care.

Culture and practice, informed by Human Caring Theory, values diversity, and honors the inter-subjective, I-thou relationship of nurse-patient-family-healthcare team members (Watson, 2012). This relationship values the ethics of care, face, heart and hand; and supports a humanistic, transpersonal orientation to caring for self and other (Watson). Watson, Biley and

Biley (2002) illuminate the notion of the inherent healing, therapeutic and energetic presence in all human beings, and stress the importance of self-care and reflective practices for nurses. They believe that nurses who participate in daily holistic self-care practices, aimed at personal and professional growth, are able to be more authentically present in the caring-healing relationship. Some hospitals that have implemented nursing practice models based on Human Caring Theory have developed a caring-healing environment, structures and processes to promote integral health for nurses, patients, families and the healthcare team (Bent, Burke, Eckman, Hottmann, McCabe & Williams, 2005; Ryan, 2005). Watson (2011) has certified several hospitals that have successfully infused her theory into nursing leadership, staff, system and patient care practices, as exemplars of Caring Science.

Human Caring theory guided practice has been measured both quantitatively and qualitatively in a number of Magnet[®] designated hospitals (Watson, 2009). Watson cites many survey tools that have been developed, tested and used to measure the patient, family, nurse and administrators' perception of caring. To date, none have been found that address the emancipatory praxis of Integral Nursing as informed by Human Caring Theory in the acute care Magnet[®] designated hospital. Nursing research by Bent et al. (2005); Pipe (2007, 2008); Ryan (2005), Drenkard (2008), Woodward (2004), Stuller (2004), Donius (2003), and Watson and Foster (2003) discuss the implementation and outcomes of theory guided practice models based on Watson's Theory of Human Caring in Magnet[®] hospitals. While the research demonstrates both qualitative and quantitative improvement in nursing and patient satisfaction, and increased nursing staff retention rates resulting from the shift towards a humanistic, caring-healing model of care (Bent et al.; Drenkard;); further evidence is needed to better understand the emancipatory

experience of nurses as they embody the values, knowledge and language of nursing qua nursing within the unitary transformative integral-holistic paradigm of Caring Science.

1.10 Statement of the Problem

There is a limited amount of research generated by and with nurses utilizing an emancipatory praxis approach, which is designed to facilitate participants understanding of ideology and social behavior as it relates to how nurses are impacted by the Human Caring theory to guide their practice in the clinical Magnet[®] healthcare environment. This research study investigated nurses' experience of Human Caring Theory in practice, using critical narrative methodology (Kim, 1999, 2007, 2010) to determine how nurses feel, think, act and would like to evolve in a single Magnet[®] re-designated healthcare system. Insight into the ideology, values and beliefs that nurses hold about themselves and their experiences, through the process of emancipatory dialogue, may lead to renewed and enhanced nursing empowerment and positively impact the health of nurses, patients, others in the healthcare environment and even the environment and system itself (Lather, 1991; Chinn & Kramer, 2008; Quinn, 2003; Boykin, 2005; Watson, 2012; Davidson, Ray & Turkel, 2010).

Extant nursing scholars call for a refocusing of the nursing lens from the normative views of contemporary nursing practice, that are predominantly concerned with the required dominant medical-technical aspects of the acute care nurse role, to an expanded view of a relationship based, situated, caring-healing-integral health metaparadigm. The latter implies the essence of nursing is steeped in the theoretically grounded, rich, situational-context of the social-ethical-moral-values based experience of nurses with self, others and the complex adaptive environments in which they live, learn and practice.

1.11 Purpose

The purpose of this study was to investigate the nurse's experience of nursing qua nursing as expressed through their narratives, in a Magnet[®] re-designated healthcare environment that participates in the Theory of Human Caring to inform their professional practice. The active participation of nurses in dialogue about their experiences in this context generated emancipatory knowledge. Emancipatory knowledge was gained through a critical narrative process of story, reflection and critique using dialogue, which aimed to raise nurse's consciousness and facilitate transformative learning of her/his social condition. This research methodology brought to light hegemonic presuppositions and value-laden beliefs that informed nurse comportment and self-agency (Lather, 1991; Kim, 1999, 2007, 2010; Mezirow, 2000; Chinn & Kramer, 2008, Benner, Kyriakidis & Stannard, 2011).

1.12 Background

The background for the study explored the concept of nursing qua nursing; including factors related to caring, healing, and complementary therapies in nursing. It also explored Magnet[®] re-designation, structural empowerment and the professional practice model informed by Human Caring Theory. It situated the notion of integral nursing as a means for nurses to embody an emancipated praxis (theory-practice-research) of nursing qua nursing. Multiple nursing studies exist separately in the emancipatory praxis paradigm (Jacobs, Fontana, Kehoe, Matarese, & Chinn, 2005; Hemsley & Glass, 1999; Kagan, Smith, Cowling & Chinn, 2009; Jarrin, 2006) and the holistic nursing paradigm (AHNA; Gagner-Tjellesen, Yurkovich, & Gragert, 2001), on clinical Magnet[®] environment outcomes (Aiken, Havens & Sloan, 2000; Aiken, 2008; Armstrong & Laschinger, 2006) and on Human Caring Science (Bent, Burke, Eckman, Hottmann, McCabe & Williams, 2005; Britt Pipe, 2007, 2008; Ryan, 2005; Drenkard,

2008, Woodward, 2004; Stuller, 2004; Watson and Foster, 2003; Nelson, DiNapoli, Turkel & Watson, 2012). Contesting hegemony and sparking transformation begins with awareness, consciousness-raising, and creative vision for a future that is informed of the value of nursing as a caring-healing profession that positively impacts the integral health of persons and environments.

1.13 Significance of the Study

The significance of this study was it identified the patterns that facilitate or hinder nurse empowerment to utilize an integral-holistic, caring-healing, theory guided approach to the care of self, co-workers, patients, patients' family and the environment. Findings from this study helped to identify opportunities for nursing education and leadership to facilitate the empowerment of nurses in the theory guided Magnet[®] re-designated clinical environment and added to the science of Integral Nursing and Human Caring. It helped to foster enhanced awareness and opportunities toward integral health and increased knowledge of metaparadigm concepts in action for the participant nurses. This study further supported the nursing professions' articulation of its unique value to the healthcare system beyond the scope of the clinical Magnet[®] environment to empower healthy people and environments. It also helped to understand the impact of nursing qua nursing upon nurses who are impacted by constantly changing environments within the workplace as the result of mergers and acquisitions in healthcare.

This study addressed the gap in the literature regarding the factors that impact the ideology and empowerment of nursing qua nursing in the nursing profession, thereby providing a basis for building knowledge related to the social beliefs that nurses' hold about themselves, each other and the profession. Future research may be conducted to identify the factors that influence nurse ideology and social behavior in other practice and cultural milieus. Additional

research in this area may generate strategies to help nurses identify and contest the hegemony that may disempower them and thereby evolve the profession towards further maturation and independence.

1.14 Research Questions

This study addressed four research questions:

1. What are the emancipatory experiences of nurses in a Magnet[®] re-designated hospital that promotes Human Caring Theory?
2. What are the patterns that facilitate nurses' comportment and self-agency to fully embody and practice integral nursing qua nursing in a Magnet[®] re-designated healthcare system?
3. What are the patterns that create barriers to nurses' comportment and self-agency to fully embody and practice integral nursing qua nursing in a Magnet[®] re-designated healthcare system?
4. How does the organization support nurses' control over their nursing practice within this one ANCC Magnet[®] re-designated healthcare system?

1.15 Summary

This section provided an overview of the research study. It discussed the Theory of Integral Nursing as an overarching grand theory and the Theory of Human Caring as a philosophical and ontological framework to fully understand nursing qua nursing for what nursing is and can be. This section also introduced the use of emancipatory praxis as a means of raising consciousness through reflection and dialogue. Epistemology generated by critical narrative inquiry utilizes reflection and dialogue to investigate the patterns that facilitate and create barriers towards optimizing comportment and self-agency for nurses. Several salient studies (Persky, Nelson, Watson & Bent, 2008; Bent, Burke, Eckman, Hottmann, McCabe &

Williams, 2005; Jacobs, Fontana, Kehoe, Matarese & Chinn, 2005; Jarrin, 2003; Kagan, Smith, Cowling & Chinn, 2009; Drenkard, 2008) were introduced that supported the need for this study in this section.

The next chapter provides an integrated literature review of the research on this topic. It delves into greater depth regarding emancipatory knowledge development, critical social theory, the Theory of Integral Nursing, the Theory of Human Caring, Unitary-Transformative nursing paradigm and related nursing theories, the Theory of Cultural Transformation and partnership social systems, and the application of theory guided practice in the ANCC Magnet[®] environment.

Chapter Two

2. Review of the Literature

This section provided a review and synthesis of the available literature related to nurses emancipatory experience in using Human Caring Theory to guide clinical practice in an ANCC Magnet[®] re-designated healthcare system. The aim of this literature review was to synthesize current literature regarding nurses' experience using Human Caring theory guided practice in an ANCC Magnet[®] re-designated healthcare system related to facilitators and barriers of integral nursing, emancipatory praxis and structural empowerment. Integral-holistic nursing practice includes the use of caring-healing modalities and independent therapeutic nursing interventions (ie: acupressure, acupuncture, aromatherapy, authentic presencing and patterning, guided imagery, healing environment, healing touch, health counseling, massage, music, and Reiki). The philosophical and theoretical frameworks upon which this study is based are the Theories of Human Caring and Integral Nursing, emancipatory knowledge development and praxis, and the development of transformative-desiderative knowledge and clinical wisdom through critical narrative inquiry (Lather, 1996; Benner, 1984; Benner, Kyriakidis & Stannard, 2011; Dossey, 2008; Watson, 2012; Chinn & Kramer, 2008; Kim, 1999, 2007, 2010, 2012)

A review of the literature was conducted using electronic and published written resources with selection criteria including relevant factors and terms related to emancipatory praxis, critical social theory, feminist research, Integral Nursing and integral health, caring and healing, holistic nursing, Human Caring Science, Magnet[®], control over nursing practice and structural empowerment. Peer reviewed research databases utilized for the literature search included Academic Search Premier, EBSCO host, Proquest, CINAHL, PubMed and Google Scholar. Secondary sources included literature from the Watson Caring Science Institute, the American

Holistic Nurses Association, the American Nurses Association, the American Nurses Credentialing Center, the National Institute of Health and the National Center for Complementary and Alternative Medicine, and the New York State Office of the Professions Health Education Department.

The literature search generated resources from the past thirty years from 1981 to 2011. Salient historical sources germane to nursing as a caring-healing art and science, holistic nursing as praxis, the Theory of Human Caring, the Theory of Integral Nursing, integral health, feminist-empowerment methodology, and critical social theory were also selected. Relevant terms and key words utilized during the search included: Emancipatory praxis, holistic nursing, Integral Nursing, Human Caring and theory guided practice, caring, healing, nursing qua nursing, ANCC Magnet[®] structural empowerment and control over nursing practice. Selection criteria for review also included the structure and culture of the clinical Magnet[®] environment, Magnet[®] outcome studies, nurse's perception of empowerment and the work environment, application of Human Caring theory guided practice and the use of integral-holistic caring-healing modalities as independent therapeutic nursing interventions.

2.1 Emancipatory Praxis Research

The purpose of emancipatory research is to raise the consciousness of participants, so that they can experience transformation through mutual learning and dialogue. Fine and Weis (2008) define the scientific and social significance of the emancipatory research process and state, "Social theorists know that the web that connects structures, relations, and lives are essential to understanding the rhythm for daily life, possibilities for social change and the ways in which individuals take form in, and transform social relations" (p.89). Emancipatory praxis research is situated in the critical social, postmodern, post-positivist, human social science,

phenomenological paradigm; and is associated with critical, feminist, ethnographic, and action research (Denzin & Lincoln, 2008).

In regards to the literature review of the research topic, one salient participatory action study was found (Persky, Nelson, Watson & Bent, 2008); however, no emancipatory praxis studies were found that critically investigated the impact of using Watson's Theory of Human Caring to guide nursing practice. Most studies focused on the impact of Human Caring upon nursing satisfaction, recruitment and retention, and these studies were excluded from this literature review as the evidence strongly supports these Caring Science outcomes. Only one emancipatory praxis study conducted with senior nursing students in New Zealand was found (McLeland & Williams, 2002). Three nursing praxis studies were found that reflect or represent the unitary transformative paradigm; two utilizing Newman's Theory (Endo, 2004; Kilpatrick, 2008), and one utilizing Roger's Theory as a praxis model of care (Lincoln, 2009). These studies were selected for this literature review because they are helpful for understanding the concepts of praxis and integral-holistic nursing in relation to the patterns that create facilitators and barriers to theory guided practice within the unitary-transformative paradigm.

Praxis in the nursing literature is associated with healing and holistic nursing, and is linked theoretically to Newman's Theory of Health as Expanding Consciousness (2002). Newman describes praxis research as a means to reveal the nature of nursing practice by recognizing patterns. For Newman, nursing praxis (theory-practice-research) is concerned with the whole unitary pattern of health as expanding consciousness. When one views health, one must take a broad view and identify salient patterns that are evolving, repeating and needing attention. Both unitary and emancipatory knowledge transcend and include a priori knowledge. A unitary view includes physical, mental, emotional, spiritual, social, interpersonal, and

integrative processes and perspectives of the human health experience. For Newman, each person, in each evolving moment, expresses a unique pattern that possesses meaning. “Research as nursing praxis” requires nurse and patient self-reflection aimed to develop a deeper and wider view for understanding of one’s unitary health pattern, and the influences these patterns have upon one’s health. In concurrence with Newman, Walker and Redman (1999) state, “Theory-guided, evidenced based reflective practice (praxis) is the core of nursing education and practice” (p. 299).

Hines (n.d.), Kilpatrick (2008), Endo (2004), and McLeland and Williams (2002) discuss emancipatory nursing praxis as a method to see and do nursing qua nursing. Hines states, “Praxis is the synthesis of thoughtful reflection, caring, and action within a theory and research-driven practice” (p. 1). She discusses the impact of nurse comportment related to a humanitarian, values based, relational ontology as the means towards designing a new future for nursing that transcends current boundaries and barriers. The notion of synchronicity is raised in relation to emancipatory praxis; where all patterns of knowing, doing and being are present in the caring moment (Hines). She cites the works of Chinn and Kramer (2008) and Watson (1999, 2004) as influencing her thesis.

Kilpatrick (2008) discusses praxis as the basis for ontological, epistemological and nurse practitioner role development. Kilpatrick advises that praxis permeates practice and influences the structuring of relationships with colleagues, patients and families in the work environment. She developed a thesis that supports the use of a praxis framework in the education of advanced practice nurses. Kilpatrick credits Newman’s (2002) description of praxis as the art-science-practice of nursing which forms the basis for her educational design.

For Kilpatrick (2009), Hines (n.d.) and Newman (2002), there is an ideological basis and commitment to seeing, thinking about, and doing nursing praxis through a theoretical lens. In a praxis framework the nurse is an action researcher and theory generator, who utilizes a process of reflection and dialogue to achieve transformation. Kim (2010) places the critical inquiry of praxis in the transformative sphere of nursing knowledge development. Transformation is inherently a change process. Change is achieved through a critique of the ideological, institutional, cultural, economic and sociopolitical structures that impact one's inter-subjective and inter-objective experience. This process of change starts at the micro level with self and the nurse-patient interpersonal relationship, and may evolve to the macro level of the nurse-healthcare system relationship (Kilpatrick, 2009; Kim).

Endo (2004) used Newman's nursing as a praxis approach to theory guided nurse partnership in three different, but related contexts on an inpatient oncology unit, with: 1) families of patients with cancer, 2) oncology unit nurse leaders, and 3) oncology unit practicing staff nurses. The study used a participatory action research design. The author did not specify how many participants were included in the study. The design for data collection included the researchers interviewing participants on three separate occasions, and reiterating pattern recognition through dialogue until meanings emerged. The researchers used journals and written narrative audio transcripts for data collection and analysis. Endo discussed how the researchers developed a tolerance for the uncertainty and chaos that naturally occurred before a new pattern and meaning coherently emerged. The concept of pattern recognition and the notion of chaos to coherence during transformative change are cited frequently in the unitary-transformative paradigm literature (Endo; Newman, 2002). The interviews were completed once the new pattern and meaning emerged. A praxis project team was developed with staff nurses, nurse leaders,

educators and researchers. As nurses began to recognize theoretical manifestations in practice, through a reflective dialogue process, they were able to shift from a medical model view to a unitary transformative, health as partnership view, resonating with Newman's (2002) theoretically informed model of care. Endo describes Newman's praxis as transformative nursing, affecting all participants and contributing to nursing knowledge as a practice discipline.

Lincoln (2009), a Rogerian scholar, and advanced practice holistic nurse, describes holistic nursing praxis as the intersection between theory, practice, research and education. She discusses the creation and integration of a holistic nursing model of care in an eighty six-bed community hospital in the mid-western United States. The holistic nursing model blends high technology with high touch, holistic theory-guided nursing care. The pilot project aim was to integrate Roger's Theory of the Science of Unitary Beings (SUB) into practice in the acute care environment. The participants self-selected based on: 1) their interest in holistic nursing; 2) possession of strong clinical skills; and 3) upon their interest in the project and desire to learn more about the topic. Nurse learning needs were assessed using the American Holistic Nurses Association (AHNA) nursing education assessment tool (n.d.). The nurse participants (the number of participants was not specified) attended a holistic nursing education program grounded in Rogerian ontology and designed by Lincoln. After one year, all registered nurses in the hospital were surveyed to identify barriers to holistic practice. The survey findings were used by the holistic nurse practice council to develop strategies and practices to overcome barriers, and fully integrate SUB theoretically grounded holistic care into hospital nursing practice. Lincoln discusses her role as a nurse educator and leader in bridging language barriers from academia to practice, so that nurses with limited education of theoretical concepts may better

understand, and consciously utilize philosophical constructs and multiple patterns of knowing within their practice and in caring for themselves.

Lincoln (2009) states the holistic model of care is taught to nurses using the “Four A’s: Awareness, Access, Appreciation and Action” (p. 64). The healing arts education program teaches nurses to use caring-healing modalities such as healing touch, Reiki, therapeutic touch, aromatherapy, acupressure, guided imagery, healing music and massage in their practice. Nurses are taught to be aware of their thoughts, feelings, beliefs and intentions for healing as they are viewed as integral to Rogerian theoretical concepts of pan-dimensionality, energy fields, interconnection, co-evolution, relationship, unity and integrality. Antecedent to co-participation with patients, the nurse must acknowledge and embrace her/his consciousness and compassion, thereby fostering balance and well-being in creating a healing internal and external environment. Project outcomes were described by Lincoln as improved nursing satisfaction and engagement scores, according to Gallup polls.

In an emancipatory praxis study with senior nursing students in New Zealand, McLeland and Williams (2002) describe the outcomes of nurse socialization in the acute care hospital environment from the idyllic academic environment. The purpose of the study was to better understand the learning experiences of nine Bachelors of Science nursing students in the clinical setting. Participants were recruited via fliers placed on campus. Participants contacted the researchers to enroll in the study. After selection and informed consent, each participant chose their own fictitious name to protect anonymity. Participants were interviewed first individually and then subsequently as a group. Qualitative data was recorded, thematically analyzed and validated with an independent expert researcher. The study findings showed that nursing students felt marginalized, exploited and powerless as they were forced to shift from a holistic conceptual

model in the academic setting to a biotechnical task focus when providing care to hospitalized patients. Facilitators to praxis were identified as making time for reflection on practice and action, dialogue with educators, and the use of a collaborative, holistic and participatory education-practice model. Financial and time constraints were identified as barriers to nursing praxis and quality learning experiences. McLeland and Williams conclude that nurses are marginalized by patriarchal domination, and the hierarchal and structural oppression that exists in the hospital environment. The domination and oppression of nursing practice in hospital and educational environments and structures resonates with scholars' findings in the United States (Jacobs et al., 2005; Clark, 2005, 2010; Jarrin, 2011, 2012; Kagan et al., 2009).

Clark (2005) argues that to develop integral-humanistic foci for nursing practice and healthcare, we must start by transforming our approach to nursing education and leadership from a dominator, behaviorist-medical, patriarchal model to a partnership social system if we are to align with a humanistic philosophy of care. Clark's argument is validated by the Foucauldian perspective that knowledge is power (Foucault, 1982; McCabe & Holmes, 2009), and is supported by Eisler's (2002, 2010) partnership system. According to Eisler the dominator system is rigid, hierarchal and authoritarian as compared to the partnership social system that is egalitarian, flexible, caring and mutually respectful of diversity and the sharing of power. The process of nurse socialization into the healthcare milieu is an educational process of cultural transformation (Clark, 2005). Power relationships are learned through language, behaviors and relationships with others. Critical inquiry into the socialized sources of knowledge and power, by and for nurses, using a partnership approach, may help nurses to identify the barriers and facilitators to nursing qua nursing and meet the transformative cognitive needs of the nurse (Clark, 2005; Kim, 2010; Chinn & Kramer, 2008).

2.2 Emancipatory Knowledge Development

Chinn and Kramer (2008, 2011) present a model for emancipatory knowledge development that places praxis at the center of a critical inquiry. Praxis is surrounded by critical questions and creative processes that use the techniques of critiquing and imagining, and assisting one to develop formal expressions of emancipatory knowledge (See Figure 1 for Chinn & Kramer's Emancipatory Knowing Model). From this vantage point, one can develop an action plan and vision for a new future. The new future is formed through critical analysis, and a manifesto is created through the continual process of reflection and action. Sustainability is achieved through empowerment as social equity and demystification of one's situation is also fostered. Arrows to and from the center and margins of the model ask four critical questions for inquiry as depicted in the figure below: (1) What are the barriers to freedom; (2) What is invisible; (3) Who benefits; and (4) What is wrong with this picture?

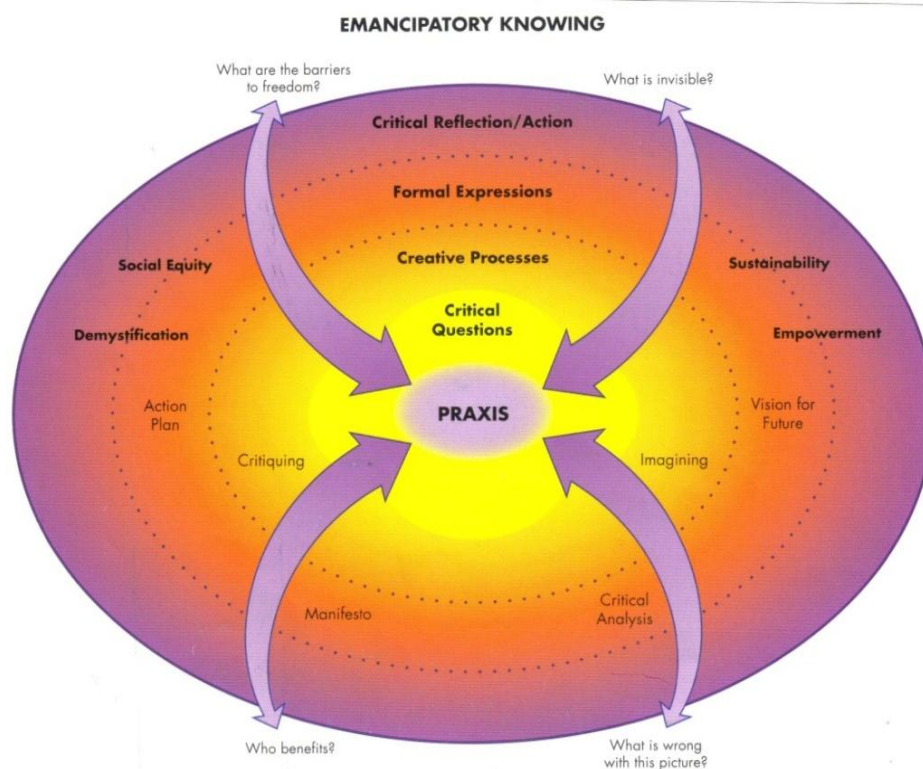


Figure 1: The Emancipatory Knowing Model (Chinn & Kramer, 2008)

In regards to the knowledge-caring-power dialect of the practice environment and nurses' relationships with those in power, one must further examine the history and sources of how power is prescribed, ascribed, and maintained. Jacobs et al. (2005), Clark (2005, 2010) and Kagan et al. (2009) found that nurses experience oppression, and may lack the education and skills required to generate emancipatory knowledge and action. Through the process of socio-cultural and academic education, nurses (and other healthcare providers) place themselves in prescribed social categories and ascribe levels of power to those categories (McCabe & Holmes, 2009). Foucauldian thought embraces the notions that: 1) knowledge is power; 2) power is a socially embedded process; and 3) power is everywhere and in everyone (McCabe & Holmes). The social behavior of individuals and groups is an acculturated guide to social knowledge,

thought, belief, power and action. Emancipation involves the illumination of dominating beliefs and behaviors, followed by a process of applied self-re-creation and renewal. Parse (2007) describes the nursing art of “humanbecoming” as a lived unfolding of meaning that is illuminated to one who lives authentically in the world. We are always in the process of coming to know and finding meaning in our experiences of living in a dynamic, ever changing universe (Parse). Emancipation involves illuminating one’s thoughts, beliefs and actions as one authentically “becomes” in relation to one’s environments (internal and external).

In the Foucauldian tradition, emancipation is two-fold: 1) the individual and/or group identify dominant ideologies and their effect on conduct, thereby becoming aware of their social prescription and behaviors (ie: a set of truths); and 2) the individual and/or group mobilize the technologies of self to create a new set of truths designed to improve a condition or situation (McCabe & Holmes, 2009). The role of the researcher in an emancipatory study is one of “caring agent who exercises authoritative expertise in a pastoral manner that encourages participant reflexivity and guides her/him in a process of self-reflection and exploration of the conditions and beliefs of her/his situation” (McCabe & Holmes, p. 1523).

The concept of emancipation and the notion of nurse as an expert caring agent are supported by Falk-Rafael’s work (1998, 2001). In her 1998 study, she describes the concept of empowered caring by “nurses who run with the wolves” as those who actively demonstrate enabling power, and provide holistic caring that includes social, economic, and political determinants of health, even against popular dominant ideology. Her landmark 1998 emancipatory study was conducted using the oral historical narratives of nurses. She framed caring dialectic theory in her analysis of the nurse’s narratives, codified her findings with news stories of the period, and validated her findings with member checking. Falk-Rafael (1998, 2001)

found that nurses were largely ordered to care by systems, administrators, managers and medical providers. This approach of “ordered caring” disempowered nurses in their decisions to control their own practice.

Although nurses may feel and be disempowered in some contexts, the study findings of Jacobs et al. (2005) found that nurses want to transform these conditions, given the awareness and ability to do so. Falk-Rafael (2001) asks a critical salient question, still relevant today and to this research study, she states, “What will allow the ‘wild nurse’ to emerge so that nursing might be actualized within its caring-healing paradigm?” (p. 30). The “wild nurse” challenges the status quo, and takes brave steps to assert her/himself against dominant ideology and normative socio-cultural mores by engaging her/his freedom, knowledge, voice and power with the intent of advocating for, and actualizing an emancipatory, unitary-transformative, caring-healing paradigm (Falk Rafael).

Emancipatory knowledge is developed from the idea of all patterns of knowing and not knowing/ unknowing converging into an epistemological and ontological context of person with environments (Carper, 1978; Silva, Sorrell & Sorrell, 1995; Munhall, 1993; White, 1995; Chinn & Kramer, 2008; Watson, 2012; Dossey, 2008; Wilber, 2000). Emancipatory knowledge includes ways of being, knowing and doing that generate humanistic understanding and meaning through the experience of existential, non-judgmental, participation-observation resulting in an evolved view. In the evolved view of one’s situation, one can see the relationship of knowledge-power-caring-healing from a vantage point that allows transformation and new associations to occur. Graham (n.d.) said, “There is a vitality, a life force, an energy, a quickening that is translated through you into action, and because there is only one of you in all time, this expression is unique” (http://www.brainyquote.com/quotes/authors/m/martha_graham_2.html).

The emancipated integral nurse's role is to facilitate personal and professional unique expression, and potential for the betterment of health and society. A salutogenic, integral, humanistic health care model as described by Scharmer (2008), Dossey (2008) and Watson (2012) implores the nurse as provider of care to look inward, outward and upward to see a new path towards enlightenment, freedom and fulfillment.

Heath (1998) describes the use of reflection and multiple patterns of knowing in nursing as it relates to theory guided practice. She discusses the concept of not knowing and unknowing, defined by Munhall (1993) and White (1995) as the place of new possibilities, and the place where hegemony resides. Heath advises nurses to examine the concept of voice as it pertains to power and critical questions about the profession of nursing and the hegemony it accepts. Socio-politically nurses accept the status quo as a means of survival, but Heath raises two critical questions: 1) Where is my voice heard; and 2) How can my voice be heard in a wider arena? Emancipatory knowledge development helps the nurse to identify issues that involve voice and power.

The concept of voice was examined by Beck (2006) in her study investigating the meaning of nurses' voice in a Magnet[®] hospital workplace. Beck describes the concept of voice as autonomy, self-awareness, and power. She conducted a phenomenological qualitative study with 12 nurses who worked five years or more on a medical surgical unit in a Magnet[®] designated hospital in the Northeast United States. Nurse education levels ranged from Diploma to Bachelors of Science degrees. Beck collected data from semi-structured interviews, reflexive and observational notes. She conducted a thematic analysis and identified major themes from the data. Beck found nurses did not feel their voice was heard, and identified the impact of nurse

manager, physician-nurse relationship, staffing, and committee structure upon their ability to have a voice.

Clark (2010) links a lack of education to decreased power and voice in nursing, and states, “I have found the majority of undergraduate prepared nurses are not prepared to take political action, know very little about ethical decision making processes, and are challenged to act as valued leaders and create change in systems” (p. 8). Clark believes nurses have difficulty working autonomously beyond technical bedside competence, and therefore, lack the role fulfillment that can come with integrating holistic caring-healing competencies into practice. Understanding of integral health, autonomy, power, voice, unity, social justice and sovereignty may be enhanced by critically evaluating the structures and stereotypes that inhibit and oppress nurses from practicing nursing qua nursing (Jarrin, 2006; Chinn & Kramer, 2008; Clark, 2005, 2010; Kagan et al., 2009; Jacobs et al., 2005).

Chinn and Kramer’s (2008) critical questions of, what are the barriers to freedom, what is invisible, who benefits, and what is wrong with this picture, can help the nurse find her/his voice. Through the process of finding one’s voice, consciousness-raising, action and change can occur. In regards to the notion of consciousness-raising, Green (2007) discusses Merleau Ponty’s (1964) concept of the “primacy of perception” in all transactional encounters. Green advises that all transactional encounters involve and result in, evolved experiential consciousness. Experiential consciousness is the process of being and becoming in which one person encounters and interacts with another. Within each person are stored meanings based on one’s understanding of the world and her/his place in it. Stored meanings are influenced by culture and expressed in language (Merleau Ponty; Green). Personal and cultural habits of thought, feelings and behaviors, and one’s capacity for change, impact one’s ability to open to new possibilities.

Emancipatory knowledge development and research involves evaluating the nurses' perception of her/his experience in the culture as expressed through language (narrative). Chinn and Kramer's (2008, 2011) notion of imagining a vision for the future begins with asking critical questions and reflecting upon one's praxiologic experience. In praxiologic experience, theory illuminates the successes and struggles of a social group (Holmes, 1993; Lather, 1986). Critical feminist social theory is the underlying philosophical framework for emancipatory knowledge development.

2.3 Critical Feminist Social Theory

Critical feminist social theory is the critique of social relationships, situations and cultures that historically oppress, discriminate against and stereotype participants based on gender and class (Gilligan, 1977; Lather, 1986, 1988, 1991, 1998 ; Ray, 1992, 1994; Thompson, 1985, 1987, 1993, 2007; Chinn, 2003; Kim, 1999, 2007, 2010; Welch, 1999; Weaver & Olson, 2006; Rose & Glass, 2008). Critical theory has roots in Marxism and the Frankfurt School of the 1920s. Critical theorists believe human action is influenced by one's inter-subjective social situation, derived from historical, cultural and political context (Habermas, 1970; Friere, 1993; Dunphey & Longo, 2007). Epistemologically the knowledge developed in this theoretical framework is aimed at socio-political emancipation. The goal of critical theory is to see one's situation anew by freeing one's perceptions from ideological constraints. In a sense, critical theory is revolutionary as it questions the status quo and is concerned with examining power structures and understanding the inter-subjectivity of human action, relationships and life.

According to Dunphey and Longo (2007), the application of critical social theory to research requires a methodology that is consistent with the theoretical constructs as outlined by Habermas (1970). To be methodologically sound the researcher must: 1) conduct an analysis that

unveils hidden power sources; 2) be a full and equal participant; 3) facilitate the full and equal participation of subjects; and 4) commit the study to mutually agreed social change. For Freire (1993) this approach involves humanistic and libertarian pedagogy with two distinct methodologic stages: 1) the oppressed people unveil the oppression they are experiencing and commit to transformative change using praxis; and 2) the pedagogy of the oppressed becomes that of the people through the process of liberation. Critical social theory is a theory of cultural change.

In regards to nursing, Dunphey and Longo (2007) suggest nurses are an oppressed group, largely and historically feminine in gender, with a position less powerful and of lower socioeconomic class than the dominating medical hierarchy that is largely and historically masculine. Issues of feminism and patriarchy are found in the nursing-medicine social context. In the domination hierarchy that exists in the healthcare system, the value and recognition of what nurses bring to the healthcare arena is suppressed (Dunphey & Longo; Clark, 2005). Clark asserts that the impact of the dominator system of medicine and managerialism affects, controls and suppresses the nurse from her/his full expression of an integral-holistic caring-healing potential.

Kim (2010) describes critical hermeneutic knowledge development as located in the sphere of the transformative cognitive needs of nurses. Kim describes a critical ontology that encompasses practice, freedom, social praxis and human agency. Kim states, "Human agency is associated with the conditions of human engagement with other humans, and in social situations framed within the concept of freedom" (p.53). Kim advises that it is inevitable that one will experience struggle, domination, disharmony and constraint when exercising freedom in any social situation. Kim describes the social situation in context to societal factors and defined

systems of power, status and expectations. The nurse's role is to facilitate freedom and self-agency for her/himself and patients to positively impact health.

The concept of enhancing wellbeing and self-agency, through examining one's relation to freedom, education and morality, was discussed by Dewey (1938) in his work on experience and education. According to Dewey, one must learn how to learn, and learn how to be free.

Alexander (1923) was a teacher and colleague of Dewey's who said, "The bridging of the gap between theory; with its associated beliefs, and practice, depends at every step upon the human element, for it is the nature of the reaction of the individual engaged in the task of this bridging...the carrying out of the plan or theory...that will determine the measure of success or failure" (p. v). Habits of mind and thought that affect self-agency are acquired through a teaching and learning process of psychophysical education (Alexander). It is through ourselves as nurses that we employ our own self-agency of theoretically informed knowledge and comportment to facilitate and support the agency of those we care for and with. A multitude of nursing science examines the impact of nursing care upon patients. Fewer studies exist that examine the nurse's ability and development of her/his self-agency towards a theory guided emancipated practice.

Transformative learning is an educational process that involves discourse, where one assesses her/his beliefs, assumptions, habits of mind and thought, interpretation, values and feelings in context to a situation (Taylor, 2000; Mezirow, 2000). Within the critical hermeneutic circle, one reflects upon societal-contextual experience and prescribed power relationships to identify, transform and transcend oppression (Kim, 2010). Through critical inquiry one deconstructs normative hegemony by analyzing language, communication patterns and symbolic meanings (Dunphey & Longo, 2007). According to Dunphey and Longo, "The emancipation that

is facilitated by critical social theory enables freedom from oppressive systems and brings about an awareness of the patriarchal models that exist in hospitals and universities” (p. 135).

Feminist theory has roots to the 1920’s suffragettes and the 1970’s women’s rights movement (Lather, 1991). It is concerned with correcting gender inequalities by investigating and understanding the social construction of gender issues and experience (Lather, 1996; Harding, 1995). The aim of critical feminist social theory is to correct distortions of thought and experience for the purpose of revealing and ending ideological and social inequality. Postmodern feminist inquiry is multi-paradigmatic, methodologically contextual, and interested in finding new patterns and meanings that exist in one’s gendered experience (Dunphey & Longo, 2007). According to Harding (1995), feminist research has three salient features including: 1) It focuses on the discovery of gender and its consequences in behavior, thought, beliefs, biology, history, culture, economy and social patterns; 2) It generates knowledge of women’s experiences, which historically have been suppressed, hidden and disregarded in scientific realms; and 3) It requires the researcher to situate herself/himself in the same reflexive context as the participants by fully disclosing one’s class, race, culture, and gender beliefs, assumptions and behaviors.

Harding (1995) discusses the methodology versus method question and advises methodology is the theoretical basis for a system of inquiry. On the question of method in feminist research, however, Harding advises there is not one specific method, but more an intent and states “...the method question in feminism leads us to the recognition that feminism is fundamentally a moral and political movement for the emancipation of women” (p.122). In the postmodern critical view, the emancipation of women becomes the emancipation of humanity towards a global peace and power paradigm (Chinn, 2008; Eisler, 1987, 2002, 2010).

From Eisler's (2010) perspective, the value of women's work in caring and healing for humanity is its sustainable empowerment of men and women to foster global peace, health, economics, politics, and spirituality; and thereby, inform cultural epistemology and ontology. In a partnership system, the focus is not feminism versus patriarchy; it is humanitarianism. It utilizes a pluralistic approach to the creation of structures and processes of shared power in education and social systems. A partnership social system respects and values nurturing, caring and healing, which has stereotypically been described as women's work and associated with more feminine qualities (Eisler, 2002; Eisler & Montuori, 2001).

The nursing profession historically, culturally and statistically continues to be a female gendered profession (Clark, 2005, 2010; Chinn, 2008). According to recent statistics 6.7% of the nation's 2 million nurses are men (United States Department of Health and Human Services Health Resources and Service Administration (HRSA), 2010). To facilitate a gender-holistic social system, inclusive of equality between and among genders and systems, such as medicine and nursing, Eisler (1987, 2002) advocates a re-examining of human social systems using the perspective of Cultural Transformation Theory. In Cultural Transformation Theory the two underlying models include: 1) ranking as in dominator systems ie: medicine over nursing, or biotechnical curing over unitary transformative caring and healing; and 2) linking as in partnership systems; medicine with nursing, and biotechnical curing with unitary transformative caring and healing (Eisler; Clark, 2005).

Nurses are subject to dominator systems of hierarchy in hospitals and the healthcare systems that place medicine and medical providers at the top rank (Clark, 2005). The education and integration of a gender holistic, culturally sensitive theory guided practice can help nurses

see what nursing is and can be separate from the prescribed, stereotyped and historically limited biotechnical role, as controlled by medicine and managerialism in acute care hospital practice.

In summary, the aim of social inquiry based on critical feminist theory, Millman and Kanter (1987) state, “Sociology frequently explains the status quo and therefore helps provide rationalizations for existing power distributions; yet social science should explore needed social transformations and encourage a more just, humane society” (p. 34). Thompson (1987) advises critical social theory and scholarship as a pattern of thought and action that challenges relations of power and domination in the social realm of nursing. Boychuk-Duchscher (2000) and Clark (2005, 2010) support a paradigm shift in nursing education and leadership from an authoritarian, rational-technical training approach to a socially responsible, holistic, humanistic partnership approach. Investigating the relationship of knowledge, power and privilege with a critical feminist social theory lens, can help nurses to: 1) identify oppression; 2) liberate themselves from the hegemony they knowingly or unknowingly experience and accept; and 3) develop a partnership social system where cultural transformation can occur, nurses are empowered and valued, and the ideals of holism and humanism are fully realized (Fontana, 2004; Clark; Eisler, 1987; Lather, 1991).

2.4 Theories of Human Caring and Integral Nursing

The Theory of Human Caring informs professional practice models in many Magnet[®] designated hospitals (Watson, 2012). In these hospitals, nurses are expected to demonstrate and articulate theoretical constructs in their practice (McClure & Hinshaw, 2002; Drenkard, 2008). The literature reveals the process of creating, implementing and sustaining a theoretically based practice model requires cultural transformation and the support of nursing education, leadership and the entire healthcare team (Bent et al., 2005; Britt Pipe, 2007, 2008; Ryan, 2005; Drenkard;

Woodward, 2004; Stuller, 2004; Watson & Foster, 2003). According to Watson, Caritas thinking involves transformation of self and system, towards an evolved, heart centered, humanitarian approach to care and consciousness (Watson, 2012). According to Clark (2005, 2010), Hines (n.d.), and HRSA (2010) staff nurses who work in hospital settings have limited academic exposure to holistic nursing and nursing theory. Education specific to theoretical constructs and the practical application of nursing theory to the acute care hospital setting, is most often provided by advanced practice nurses, nurse leaders and educators (Hines; Ryan, 2005; Bent et al., 2005).

Theoretical concepts of caring, healing, morality, humanitarianism, integral health and the relationship of the nurse to the patient/family and environments are central to Human Caring and unitary transformative theory guided practice (Cowling & Taliaferro, 2004; Cowling, 1999; Quinn, 2002; Ray, 1997; Watson & Smith, 2002; Nelson, DiNapoli, Turkel & Watson, 2012). The impact of human caring upon nurse and patient satisfaction is reported most frequently the literature (Parcells & Nelson, 2012). Watson is careful to distinguish human caring as more than a means to improve satisfaction and customer service. For Watson (2009a) human caring is ontology, a moral ideal, an imperative; the nurse's role is to be a healer who promotes integral health for self, patient and environment. Meta-theoretical concepts in nursing have evolved with our understanding of the need for integral health, peace, social justice and global advocacy. If we are to advance our profession and optimize our position in the healthcare system we must educate, openly utilize, and articulate the value of our meta-theoretical constructs.

Jarrin (2011, 2012) discusses the rationale for developing and utilizing a unified meta-language of meta-theoretical constructs in her philosophical inquiry of nursing meta-language. She concludes that the essence and experience of nursing informed by theory, must be brought

out from the hidden recesses of academia and nurse-centric milieu, so that the public and other health care providers can truly begin to understand and further value, what nursing is and does for the health of people, environments, social systems and populations (Jarrin).

According to Drenkard (2008, 2012), caring interventions must be well integrated into care processes. She advises nurses must be supported by nursing education and leadership with specific attention on work redesign that promotes more time for direct patient care. She also stresses the importance of a clear description of caring-healing interventions by nurses in patient care, and the need for nurse mentoring and coaching by expert and advanced practice nurses educated in theory to fully achieve a theory guided practice. These recommendations for nursing education and leadership structures and processes designed to facilitate and support theory guided practice are echoed by others (Ryan, 2005, Bent et al., 2005; Britt Pipe, 2007, 2008).

The impact of a theoretically informed practice of human caring upon nurses was demonstrated by Gregg and Magilvy's (2004) work. Gregg and Magilvy examined the values of Japanese nurses who use human caring constructs in their clinical hospital nursing practice. The aim of the study was to describe nurse's values and illuminate caring constructs in their practice. Through a qualitative design using descriptive data collection and analysis, they interviewed and observed 24 nurses at work, and found nurses: 1) wanted to make a difference; 2) believed nursing is a means toward self-actualization and brings meaning to one's life; 3) valued being with, listening to and touching their patients' lives; 4) valued connecting with and advocating for their patients; 5) valued having the knowledge and skill to care; 6) valued cooperating with and helping other nurses; and 7) valued their relationships as a human being. Gregg and Magilvy demonstrated that caring values of nurses exist within the acute medical model role of hospital nursing.

In regard to values and caring, Watson and Smith (2002) describe Caring Science (CS) as grounded in an ethical and moral relational ontology and state:

This relational ontology... informs the epistemology, methodology, pedagogy and praxis of caring in nursing and related fields. CS embraces epistemological pluralism, seeking the underdeveloped intersection between arts and humanities and clinical sciences, that accommodates diverse ways of knowing, being-becoming, evolving; it encompasses ethical, intuitive, personal, empirical, aesthetic, and even spiritual/metaphysical ways of knowing and being (p.456).

Watson and Smith (2002) advise a multi-paradigmatic, methodologically pluralist approach to CS where method flows from the phenomenon of inquiry. Jarrin (2011) describes nursing as situated (in context) caring and states, "Nursing is caring situated in space, place, and time; shaped by internal and external environments of both the nurse and patient/client" (p. 99). As nurses, we are constantly adapting our approach and understanding to best meet our individual patient/client needs (Jarrin 2007, 2011, 2012), but how can we apply this approach to ourselves and the profession? Jarrin (2012) believes that by identifying the contextual orientation of the individual, organization, and culture, nursing can better express itself in a manner that is understandable and valued by other disciplines; eventually helping nurses to glean further economic and political independence and parity. Dossey's (2008) Theory of Integral Nursing supports a multi-paradigmatic approach to nursing as it situates itself in the current social shift of healthcare reform that focuses on prevention and chronic disease management.

Utilizing multiple patterns of knowing to understand and demonstrate the complexity of human health and healing, Dossey (2008) advises the Theory of Integral Nursing (See Figure 2 for Dossey's Theory of Integral Nursing) can inform and shape nursing praxis and pedagogy, to best position itself as a leader in local and global health advocacy and policy making. Fiandt, Forman, Megel, Pakieser and Burge (2003) also describe Integral Nursing as a framework for the evolution of the profession of nursing and describe multiple advantages to applying it to practice,

education, policy and research. Fiandt et al., Dossey, and Jarrin (2011, 2012) believe an integral worldview helps nurses to understand complexity and values as they influence the thoughts and behaviors of healthcare providers, systems and constituents. Fiandt et al.'s model is based on Beck and Cowan's Spiral Dynamics and Wilbur's All Quadrant's All levels Model (2000), as well as Carper's (1978) patterns of knowing, and Munhall (1993) and White's (1995) pattern of not knowing and unknowing in nursing. They place the experience of the nurse in relation to the nursing care context or situation in corresponding spheres of influence and understanding. Jarrin, Dossey and Fiandt et al. resonate with the notion of situated caring-healing in nursing from a multi-paradigmatic view that focuses on the value of an integral nursing practice. Investigating caring and healing as central constructs to both the Theory of Human Caring and the Theory of Integral Nursing, and the unifying meta-theoretical notion of nursing as situated caring, further elucidates nursing language and values, and gives voice to the power of nursing (Fiandt et al.; Jarrin; Dossey; Watson, 2012).

Theory of Integral Nursing

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Figure 1.1a. Healing



Figure 1.1b. Healing and Meta-Paradigm of Nursing (Nurse, Person/s, Health, Environment)

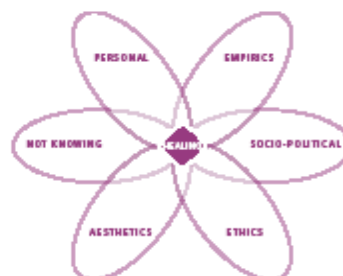


Figure 1.1c. Healing and Patterns of Knowing in Nursing (Personal, Aesthetics, Empirics, Ethics, Not Knowing, Socio-Political) Adapted from B. Capler (1978)

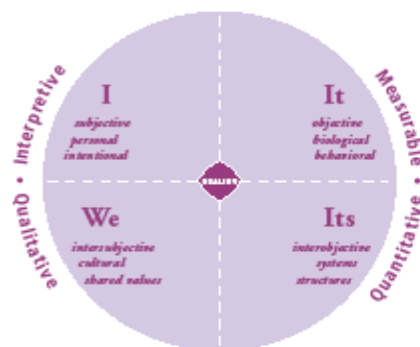


Figure 1.1d. Healing and Four Quadrants (I, We, It, Its) Adapted from K. Wilber (2000)

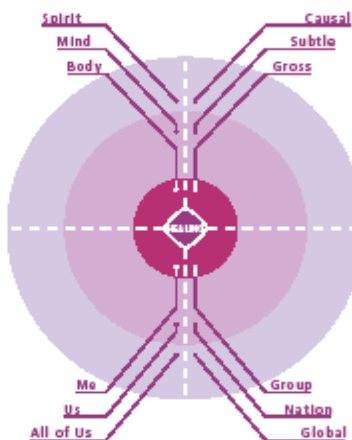
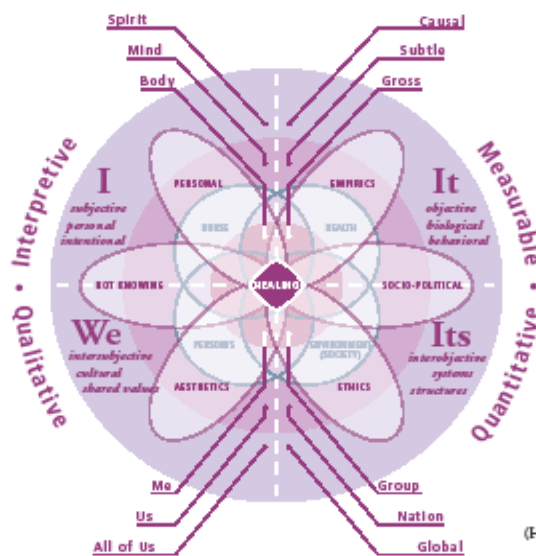


Figure 1.1e. Healing and AQAL (All Quadrants, All Levels) Adapted from K. Wilber (2000)



B. M. Dossey (2008). Integral and Holistic Nursing: Local to Global. In B. M. Dossey & L. Keegan. *Holistic Nursing: A Handbook for Practice* (5th ed.) Sudbury, MA: Jones & Bartlett.

Figure 1.1f. Theory of Integral Nursing (Healing, Meta-Paradigm, Patterns of Knowing in Nursing, Four Quadrants and AQAL)

Figure 2: The Theory of Integral Nursing (Dossey, 2008)

Caring and healing have been studied in nursing and reported in the literature as historical and conceptual analysis (Dossey, 2010; Radzynski, 2007; Smith, 1994; McElligott, 2010; Cowling & Taliaferro, 2004; Shaw, 1993; Gaut, 1993; Sanford, 2000; McCance, McKenna, & Boore, 1999; Quinn 1992, 2003; McCabe, 2007; van Maanen, 1990), in the narrative analysis of nurses' stories (McCance, McKenna, & Boore, 2001; Hudacek, 2008; Smith, Wardell, Engebretson, Hines & Zahourek, 2011), in phenomenology of nurses' lived experience (Glass, 1999; Tuohy, Stews & Brown, 2005; Rudolfsson, von Post & Eriksson, 2007; Ray, 1997;) and in descriptive and mixed method participatory action studies using surveys and focus groups (Birk, 2007; Watson, 2009; Persky, Nelson, Watson & Bent, 2008).

Smith (1994) defines nursing as caring in the human health experience, and advises that healing occurs through caring processes. Caring and healing processes reflect wholeness and growth through understanding and acceptance of one's strengths and challenges. It is well documented that nurses value their ability to care holistically and teach patients/clients to care for themselves when possible; but how do they apply these values to the care of self, profession and system?

McElligott, Capitulo, Morris and Click (2010) conducted a quasi-experimental study using pre and post-test, repeated measure and comparison group design of 100 registered nurses. Participant demographics included: ages 23- 64 years (mean= 39); 95% female; 64% Caucasian; and 58% held the degree of Bachelors of Science in Nursing (BSN). The study was conducted in a large 900 bed academic hospital setting in the Northeast, United States. Half of the nurses ($N=50$) were randomly assigned to a control group, while the other nurses ($N=50$) were provided with an 8 hour educational intervention called the Collaborative Care Model (CCM). The CCM was a professional practice model designed by advanced practice holistic nurse educators with a

focus on health promotion using Pender's (1996) Health Promotion Model, holistic nursing ethics and values based on the American Holistic Nursing Association (AHNA) standards, and interventions to create a culture of caring, healing and safety through managing the environment and facilitating positive interpersonal relationships. Both groups were given an information packet on the program and a pre and post-test survey using the Health Promoting Lifestyle Profile (HPLP) II instrument (Walker, Sechrist & Pender, 1995). The HPLP II instrument is a 52 item survey designed to assess six subscales: nutrition, health, physical activity, stress management, spiritual growth and interpersonal relations. Data from the HPLP II survey were analyzed using SPSS 15. Findings were significant ($p \leq .05$) when comparing the experimental group to the control group. The researchers found the educational intervention to be statistically significant for improving health behaviors in the experimental group. Nurses were receptive to learning and using the CCM that includes holistic health nursing interventions and Complementary and Alternative Modalities (CAM) to promote health in both nurse self-care and patient care.

Historically, nursing has been concerned with preventative, supportive and restorative care; and complementary, non-invasive therapies have always been situated in nursing (Nightingale, 1893; Snyder & Lindquist, 2001; Radzynski, 2007; Dossey & Keegan, 2009). Boundaries on this topic have become blurry, however, and some State practice acts have ruled that although nurses are to provide holistic preventative, supportive and restorative care, they must be careful not to step over the boundary by ordering and providing CAM to patients in certain settings (hospitals) without a physician, physician's assistant or nurse practitioner (MD, DO, PA or NP) order (Radzynski). Holistic nursing may include complementary and alternative health practices such as energy and bio-field therapies (Reiki, therapeutic touch and

healing touch), therapeutic massage and reflexology, use of music (audio-analgesia), use of a therapeutic, aesthetic environment, cognitive-behavioral therapies (meditation, guided imagery and relaxation, positive self-talk and contracts) and the use of self as a healing instrument through intention and authentic presence; in which the nurse combines art, science, humanities and spirituality in her/his care (Watson, Biley & Biley, 2002; Dossey & Keegan; AHNA, 2012).

Clarification of concepts related to holistic nursing practice is a means to empower nurses and facilitate autonomy. McEvoy and Duffy (2008) describe antecedents, consequences and an exemplar case of holistic nursing care in their concept analysis. McEvoy and Duffy found holistic practice increases nursing and patient satisfaction by fostering healing, unity, empowerment, communication, relationship, growth and harmony, and stipulate that the nursing environment must be conducive to caring. They cite personal and professional development, and professional autonomy and advocacy as supporting a caring-healing holistic practice. Magnet[®] designation is touted as an environment that promotes professional autonomy and advocacy for nursing excellence. The literature supports Magnet[®] designated hospitals use of Watson's Theory of Human Caring where nurses are provided the education and support to implement an autonomous holistic nursing practice that fosters caring and healing (Bent et al., 2005; Watson & Foster, 2003; Ryan, 2005).

2.5 The ANCC Magnet[®] Designated Hospital Environment and Control Over Nursing Practice

The need for higher levels of education for nurses is emerging as salient to the advancement and survival of the profession (Clark, 2010). Magnet[®] hospitals purport to address this concern by supporting advanced education for nurses, and by fostering role autonomy, control over practice, structural empowerment and self-agency (McClure & Hinshaw, 2002).

Magnet[®] designated hospitals must demonstrate optimal staffing ratios (hours per patient days) in which nurses are responsible for fewer patients, resulting in better health outcomes (McClure & Hinshaw, 2002; Keenan, 2003). Abraham, D' Emilia and Begun (2011) report 8% of all United States hospitals are now designated as having Magnet[®] status, which is considered the gold standard in quality nursing care.

To better understand the hospital nurse's experience and perception of her/his role, the 2010 Health Resources and Services Administration (HRSA) study examined how nurses used their time, the level to which they were satisfied, and limitations to their role. Nurses in the study reported the majority (75%) of their time was spent in direct patient care and charting. Non-nursing tasks were reported to take 7.6% of their time. Teaching other nurses and consultation with other care providers was reported to take the least amount of time at 7%. According to the study, staff nurses were the least likely to be satisfied with their work (when compared to nurse managers, administrators, educators and advanced practice nurses) (HRSA, 2010). Staff nurses attributed their dissatisfaction to limitations in role autonomy and self-agency. The HRSA study did not differentiate between nurses working in Magnet[®] and non-Magnet hospitals. Inadequate staffing to perform the staff nurse role has been cited as the longest and most frequent concern of hospital staff nurses (Sawyer & Wolf, 1977). The ANCC Magnet[®] model aims to address staff nurse education, role, autonomy and staffing concerns.

Using a diffusion of innovation theoretical framework, Abraham, D' Emilia and Begun (2011) studied 3,657 hospitals and found Magnet[®] hospitals; 1) were associated with increased size, complexity and specialization; and 2) compete for and receive more Bachelors prepared nurses than non-Magnet[®] hospitals in urban areas. This is consistent with the data from the average Magnet[®] organization characteristics survey (American Nurses Credentialing Center

(ANCC), 2011) that reports direct care nurse education for a hospital size between 401 and 500 beds was 47.75% Bachelor degree prepared, 38.67% Associate degree prepared, 9.28% Diploma prepared and 4.34% Masters/graduate degree prepared.

Magnet[®] designated hospitals have a shared governance structure that is designed to give nurses control over their nursing practice (McClure & Hinshaw, 2002). The concept of control over nursing practice is linked to structural empowerment, clear avenues of power, autonomy, social justice, independent nursing interventions, access to resources, respect, trust, satisfaction, support, opportunity, voice, shared decision making, positive patient outcomes and professional fulfillment (Armstrong & Laschinger, 2006; Moore & Hutchinson, 2007; Kramer & Schmalenberg, 2003; Kramer et al., 2008; Weston, 2010; Aiken, Clarke, Sloane, Lake & Cheney, 2008; Aiken, 2008; Aiken, Havens & Sloane, 2000; Brewer, 2006; Lundmark, 2008; Jennings, 2008).

Kramer et al. (2008) conducted a large study using the Conditions of Work Effectiveness Questionnaire-II (CWEQII) based on Kanter's (1993) Theory of Structural Empowerment. The CWEQII structural empowerment tool measures opportunity, information, support, resources, formal power, informal power and total empowerment (Kramer et al.). Kanter's Theory identifies information, support, resources and opportunities as lines of access to power within an organization. Kramer and Schmalenberg (2003) developed their grounded theory of Control Over Nursing Practice (CNP) from analysis of 279 Essentials of Magnetism surveys, and a constant comparative thematic analysis of 20 in person interviews with staff nurses in a Magnet[®] designated hospital. In the interviews they asked nurses to describe the extent of control they had over their practice, and to discuss a situation where they experienced control over their practice. Findings from their study helped to empirically define and characterize CNP. Characteristics of

CNP include participation in decision making, access to information and persons in power, accountability, ownership, pride, enthusiasm, increased status, prestige, respect, and a focus on positive patient and nursing care centered outcomes. An active shared governance system and structure such as a clinical/career ladder is necessary for CNP to be present in an organization as it protects, facilitates and enhances nurse self-regulation, self-determination, and CNP characteristics (Kramer et al.). Consistent with Eisler's (1987, 2002) Cultural Transformation Theory and partnership systems model, Kramer et al. found staff and leaders in Magnet[®] hospitals that demonstrated the highest level of CNP described a 'power with' versus a 'power over' culture.

The American Nurses Credentialing Center (ANCC) (2008) identifies five components or forces of magnetism inherent of structural empowerment, including: 1) an organizational structure that is flat, flexible and decentralized, where access to information flows readily in all directions; 2) personnel policies and programs that support nurses involvement, advancement and professional growth; 3) community and healthcare organization involvement including participation and engagement in professional organizations, diverse nurse practice settings, and the collaboration and development of nursing with teaching-learning and student-faculty partnerships; 4) support for the professional image of nursing including public recognition of the contribution of nurses to the health and wellness of their patients, families and communities; and 5) a commitment to professional role development including advanced education, certifications in specialties, and opportunities for lifelong learning.

Magnet[®] appraisers make designation recommendations based on data from surveys conducted by the organization and from qualitative interviewing, observation and document review (McClure & Hinshaw, 2002). In Magnet[®] hospitals, staff nurses are alleged to have

power, voice, support and recognition for their achievements. Concern exists in the literature, however, that even when Magnet[®] designation and structural empowerment exists within an organization, nurses must be motivated and have the desire to participate (Kramer et al., 2008). Research findings suggest even when nurses report the desire to participate; other factors such as inadequate staffing, relationship stress, high acuity and burnout may interfere with nurse engagement and positive outcomes (Beck, 2006; Kramer et al., 2008; Weston, 2010; Brewer, 2006; Lundmark, 2008; Jennings, 2008). In addition, McClure and Hinshaw (2002) advise that continued Magnet[®] status designation requires ongoing nurturing and involvement of nursing at all levels. How the application of professional practice models and theory guided practice, informed by Human Caring impacts the nurse's desire and motivation for participation, and how this impacts the nurses' control over practice and structural empowerment in the Magnet[®] designated hospital, requires further investigation.

2.6 Summary and Gaps in the Literature

No emancipatory praxis studies were found that examined the impact of Human Caring theory guided practice upon integral nursing qua nursing in a Magnet[®] re-designated healthcare system. Some studies were similar or related to the research topic identified in this study. One salient study utilized participatory action research (PAR), in an urban New York City hospital, to examine nursing-patient responses with caring, by using nurse-patient dyads (Persky, Nelson, Watson & Bent, 2008). Measurements of effective nurse caring in the Relationship Based Care (RBC) model, which is informed by Watson's Caring Theory, were conducted using the Healthcare Environment Survey (HES) and the Caring Factor Scale (CFS) developed by Nelson, Watson, and Inova Health System (2008). Data was analyzed quantitatively using Pearson *r* and *t* test correlations, and qualitatively for themes of caring within the theoretical constructs of

Caritas. Nurses' who scored the highest in caring constructs on the CFS, as reported by their patients, were profiled in the study as exemplar nurses who were most effective in caring.

According to Persky, Nelson, Watson and Bent (2008) exemplar nurses in their study reportedly: 1) experienced the greatest frustration with their work environment including workload; 2) had the most hospital and professional experience; 3) did not work more than their scheduled hours; 4) represented all ages; 5) were the most affected by relationship stress with patients; 6) most enjoyed coworker relationships; and 7) most often provided continuity of care to their patients. In the PAR stage of the study, the results of the survey were presented to hospital leadership and staff for the purposes of further maturing and improving the Relationship Based Care (RBC) professional practice model. This study concludes that nurses who are most effective in caring are influenced by and influence socio-cultural and emancipatory praxis domains. By conducting a critical analysis of nurses' experience of theory guided practice, new knowledge of the factors that influence the nurse in the practice environment may be further identified and addressed. From this starting point, nurses can then develop ideas of action that can empower and sustain them in the socio-political nature of caring and healing.

In another salient study that demonstrates the resolve of nurses, Jacobs et al. (2005) examined nurses' perceptions of their work experience using a critical emancipatory-feminist methodology and a dialectic process of reflection and action. Jacobs et al. (2005) found that nurses experienced powerlessness, oppression, struggle and devaluation in their practice environments. Despite this experience, nurses still perceived that they had the ability to transform these conditions. From a critical theory perspective, the disempowerment of nurses cannot be blamed on the hegemonic cultural, sociopolitical and economic forces of medicine and

managerialism alone, as nurses subscribe to their reality, knowingly or not. (Jacobs et al., 2005; Clark, 2005; Dunphey & Longo, 2007; Kagan et al., 2009).

Studies exist that verify the positive impact of holistic theory guided practice models on patient and nurse health and satisfaction (Swanson, 1999; Halldorsdottir, 2007; Parcels & Nelson, 2012). Nursing praxis studies were found that used Newman's Theory of Health as Expanded Consciousness (Newman, 2002; Endo, 2004; Kilpatrick, 2008). Mixed method participatory action and descriptive survey studies were found that used Watson's Theory of Human Caring (Persky, Nelson, Watson & Bent, 2012; Watson, 2009). No studies were found to date that applied Dossey's Theory of Integral Nursing (2008). Findings from the Nurse Manifest study by Jarrin (2006), Jacobs et al. (2005) and Kagan et al. (2009) demonstrate a need for further inquiry into the social situations that involve nurses in relation to knowledge, power, caring and the systems in which they work. Drenkard (2008) and Brewer (2006) found the need to further examine the nurse's role, quantity and distribution of work for a better understanding of the cultural impact upon work teams in organizations. Kramer et al. (2008), Beck (2006), Weston (2010) and Jennings (2008) found the need to further examine influences that affect the nurse's desire and motivation to participate in structural empowerment and have control over her/his practice.

Chinn and Kramer (2008, 2011) and Dunphey and Longo (2007) identified the need for nurses to develop a critical lens and ask questions that contest the hegemony they knowingly or unknowingly accept. Smith and Watson (2002), Dossey (2008), Clark (2010) and Jarrin (2010) identify the need for nurses to re-examine and expand meta-theoretical and meta-language constructs, in order to develop an evolved integral-unitary-transformative view of holistic nursing practice, education, and local to global health policy. Eisler (1987, 2002, 2010) discussed

a gender holistic, Cultural Transformation Theory to improve our understanding and ideas of an empowered partnership social system, which Clark advised is required for nursing to fulfill a transpersonal, Human Caring pedagogy and praxis. The need for nurses to share power with other nurses for the purpose of facilitating a dialogue and further understanding of the emancipatory praxis of integral nursing, through a critical narrative inquiry of the impact of Human Caring theory guided practice upon nursing qua nursing in an ANCC Magnet[®] re-designated healthcare system, was identified in this literature review.

The emancipatory praxis (freedom and theory in action) of integral nursing is informed by Human Caring Theory (Watson, 2012), Integral Nursing Theory (Dossey, 2008) and the process of Emancipatory Knowing (Chinn & Kramer, 2008). Integral nursing is the metatheoretical framework that is further informed by Human Caring Theory as the epistemology, ontology and metaphysical nature of nursing; and manifests as the emancipatory praxis of integral nursing. The emancipatory praxis of integral nursing is a blending of paradigms that integrate, support and enhance each other. It provides the nurse with the knowledge; power and language to identify and communicate theoretical constructs in her/his practice and thereby develop evolved comportment and self-agency of nursing qua nursing.

The next chapter explains the research methodology of emancipatory knowledge development (Chinn & Kramer, 2008) and the method of critical narrative inquiry (Kim, 1999, 2007, 2010). It describes the procedures and operational definitions that construct this study. Critical narrative inquiry is situated in the human science paradigm and is concerned with telling, hearing, reflecting, dialoguing about and analyzing nurses' stories of real life practice situations.

Chapter Three

3. Methodology

This section presents the methodology of emancipatory knowledge development, the method of critical narrative inquiry, and the procedures and operational definitions that constructed the study. The methodology aimed to: 1) generate knowledge of the socio-cultural experience, values and beliefs of nurses; and 2) raise participant nurse consciousness by gaining insight into her/his feelings, actions and thoughts as they are impacted by power relationships in the clinical Magnet[®] environment (Polit & Beck, 2004; Lather, 1996; Munhall, 2007; Chinn & Kramer, 2008; Leininger & McFarland, 2006; Kim, 1999, 2007, 2010). The purpose of this research methodology was to illuminate, transform and activate nurses understanding of the theory guided, emancipatory influences and potentials within the Magnet[®] re-designated work environment. The researcher was a participant, who advocated for and facilitated the creation of transformative learning and change within participants' ideology (Leininger & McFarland).

Transformative learning occurred through dialogic process with the researcher and participant as educational partners, in a mutual discussion that elicited the nurse's knowledge of the subject and the ideological influences that affected them (Polit & Beck, 2004; Mezirow, 2000). The transformative, dialogic process activated critical reflection and an internal and external evaluation of dogmatic practices that may have hindered her/his full expression of freedom and democracy (Polit & Beck; Mezirow; Tsang, 2007; Arman & Rehnsfeldt, 2007). According to Wolf (2007), critical inquiry studies power and hidden agendas within cultures. Cultural studies may include the macro or system/group level and/or micro or unit /person level; and encompass distinct views that are emic (phonemic: within the culture) and etic (phonetic: outside the culture) (Leininger & McFarland, 2006). Emic refers to the insider-participant

understanding of her/his culture, while etic refers to the investigators understanding of tacit knowledge, which is hidden or beneath the surface, not yet fully known to participants and researcher (Wolf). Wolf advises tacit knowledge is generated by the outsider/investigator's interpretation of theoretical and symbolic meaning from her/his experience in the culture.

Dunphey and Longo (2007) raise concern about the hegemonic forces inside and outside of nursing that covertly dominate; and advise that inquiry based on a critical social theory paradigm helps nurses see the theory-practice link and its socio-cultural impact. Kim (2007) describes critical reflective inquiry as narrative epistemology based on human activity. Kim states, "This analytic method involves scripting, analysis, critique and identification of exemplary practice scripts" (p. 210). The critical narrative inquiry process aimed to generate knowledge of the synthesis of nursing praxis (theory-practice) and included three phases: 1) descriptive; 2) reflective; and 3) critical/ emancipatory (Kim).

This section provides an overview of the method and research design used in this study. The research design included: a) operational definitions (See Appendix H for Operational Definitions); b) construct validity, rigor and trustworthiness; c) method of data collection including: setting, participant selection and role of the researcher; d) data analysis; and e) study limitations.

3.1 Research Design

The specific research design for this study was critical narrative inquiry (Kim, 1999, 2007, 2010). The rationale for choosing the research design of critical narrative inquiry was it best suited the purpose of investigating the socio-cultural beliefs, conditions and experiences of nurses in the clinical Magnet[®] environment who use Human Caring Theory as the basis for

her/his professional practice, and it fit the research topic of emancipatory praxis; which required a dialogic and reflective approach.

3.2 Specific use of the Research Method

After obtaining Institutional Review Board approval from St. Peter's Hospital and The Sage Colleges, the researcher used a qualitative critical narrative research design (descriptive, reflective, and critical/emancipatory) that involved a participatory dialogue process (Kim, 1999, 2007, 2010). This method has been verified by Kim (2012) to generate emancipatory knowledge of nursing practice from the transformative perspective of the nurse telling and analyzing her/his story to the researcher. The data evolved over time as participants described, reflected upon and analyzed her/his experience of integral nursing as informed by Human Caring theory guided practice. This study method took three months to complete as each phase was audio recorded, transcribed to written text using the NVivo 10 qualitative software program, reviewed and analyzed by researcher and participants, and member checked in each phase and at the end of the three-phase data cycle.

Kim's method of critical narrative inquiry required the researcher to interview and dialogue with each participant a total of three times. The first session provided an introduction and overview of the research topic followed by the researcher asking the nurse to tell a story, with a beginning, middle and end, that described her/his feelings, thoughts and actions of a clinical practice situation when she/he used Human Caring Theory and an integral nursing approach to care. The audio data from the first session was transcribed using NVivo 10 qualitative software, and presented to the participants by electronic mail prior to the second session. At the second session, the researcher and participant reviewed, reflected and dialogued about the findings of the first session, with specific attention to theoretical constructs and

contradictions that manifested in their stories. The audio data from session two were transcribed by the researcher using NVivo 10 qualitative software and presented to the participants prior to the third session by electronic mail. At the third session, the researcher and participant reviewed the phase two transcript data, and critically examined opportunities for emancipatory change through dialogue, by searching for transformative change that occurred through the three phase process. The audio data from session three were transcribed using NVivo 10 qualitative software and presented electronically for final member checking to the participants. This cycling of data from descriptive narrative, to reflection against the espoused theories of Human Caring and Integral Nursing, to identifying transformative learning and critical/emancipatory actual and desired change; generated answers to the study's research questions of: 1) What are the emancipatory experiences of nurses in a Magnet[®] re-designated healthcare system that promotes Human Caring Theory; 2) What are the patterns that facilitate nurses' comportment and self-agency to fully embody and practice integral nursing qua nursing in a Magnet[®] re-designated healthcare system; 3) What are the patterns that create barriers to nurses' comportment and self-agency to fully embody and practice integral nursing qua nursing in a Magnet[®] re-designated healthcare system; and 4) How does the organization support nurses control over nursing practice within this single ANCC Magnet[®] re-designated healthcare system?

3.3 Construct Validity, Trustworthiness and Rigor

Construct validity, trustworthiness and rigor were ensured by adherence to the methodological constructs of critical narrative inquiry as defined by Kim (1999, 2007, 2010). Narrative analysis was conducted, verified, clarified and member checked by the participants in three phases and upon conclusion of the study. Trustworthiness was upheld by using data from participants' stories, by conducting story analysis in the nurses' voice, and by using secure data

systems and the NVivo 10 qualitative software for transcription. Transcript data were verified by each participant in each phase of the study by providing her/him with the written narrative transcript from each prior session and at the end as a whole. In addition, both the researcher and participants were reflexive with journaling and dialoguing about her/his unique interpretation and responses to data. The researcher's reflexive notes were included and notated for date and source. Qualitative research reveals nuances, paradoxes and intricacies of meaning not readily evident to the participant and the researcher at first glance (Morse, 1998). Rigor or scientific adequacy in a qualitative research paradigm is achieved through a complex process from researcher and participant preparation, study conceptualization, data analysis, interpretation and conclusion.

Lincoln and Guba (1985) outline four (4) components of qualitative research trustworthiness including: 1) Credibility which is confidence in the truth and interpretation of the data. This can be accomplished using several approaches i.e.: prolonged engagement, snowballing with repeated interviews until saturation is met, triangulation of data to time, space, person, investigator, definition of and adherence to theory, method, analysis and multiple peer debriefing and member checking. Credibility is also achieved with use of reflexive notes by the researcher. Reflexive notes are designed to give the reader knowledge of and confidence in the researcher. Reflexive notes may include researcher biography, credentials, experiences and normative views; 2) Dependability and reliability of data refers to the stability and trustworthiness of the data over time and conditions; 3) Confirmability is achieved by developing an audit trail of data i.e.: raw data, data reduction, process notes, reflexive notes outlining the researcher's intentions and dispositions along the way; and 4) Transferability refers to how well the data can be applied to another similar group or context. Beyond the four basic tenets of

qualitative rigor described by Lincoln and Guba, each qualitative methodology has its own unique set of criteria that denotes elements of scientific rigor inherent to the paradigm itself. In this study the qualitative methodology criteria was that of critical narrative inquiry (Kim, 2010, 2012).

Munhall (2007) describes the dynamic nature of the R's of rigor for phenomenological research: resonancy, reasonableness, representativeness, recognizability, raised consciousness, readability, relevance, revelations, responsibility, richness and responsiveness. Attention was made by the researcher to integrate Munhall's ideas of rigor throughout the research process. Another view of rigor is presented by Sandelowski (1993), who recommends allowing for creative, soulful, imaginative and artistic processes to emerge, thereby avoiding destruction of the unique spirit of qualitative research with over adherence to the standards of scientific rigor. Qualitative research is a social process where the participant and the researcher are both stakeholders with interests that bridge art and science. There is a commitment and fidelity to meaning-making that is to be validated along the way during data collection, analysis and reporting. Member checking was an ongoing task that both informed and sought to clarify, elaborate and validate data. The human science, naturalist, interpretive paradigm recognizes that reality is multiple and socially constructed, thereby, influenced by the conventions and artifices of social interaction (Sandelowski).

Morse (1998) advises the qualitative researcher to use member checking continuously during data collection. The process of member checking validates research confidence in the study findings. The researcher has extensive knowledge of the topic, setting and social science, and imparts this to the process, while understanding that participants have an emic view and the research task is to bring new meaning to light. Denzin and Lincoln (2008) outline the qualitative

research process in five (5) phases: 1) the researcher as a multicultural subject; 2) theoretical paradigms and perspectives; 3) research strategies; 4) methods of collection and analysis; and 5) the art, practices and politics of interpretation and evaluation. To ensure scientific rigor, the researcher aligned conceptually with the paradigm and theories that she was operating from.

According to Denzin and Lincoln (2008), the researcher uses a strategy of inquiry that comprises a bundle of skills, assumptions and practices as he or she moves from paradigm to empirical world. Denzin and Lincoln emphasize the interpretive, artistic and sociopolitical nature of qualitative research that necessitates using evaluative criteria that is situated, relational and textual of the experience being studied. Scientific rigor in qualitative research involves a complex process that seeks to uphold meaning, protect sociopolitical ethics and bring to light new meanings and relationships of study topic and findings.

Narrative may be in the form of exemplars (commonly used in Magnet[®] hospital credentialing documents) and portrayed as stories from nurses. They are concise, reflective and evaluative, designed to capture the drama of the phenomenon (Johns, 2004). In regards to story narrative, Eberhart and Pieper (1994) state, “Stories are reflections of experience with a beginning, middle and end” (p. 47). Participants were informed of the research questions, the theoretical framework, and the elements of a story narrative and exemplar the beginning of each dialogue session, so that she or he could fully understand how to tell her or his story and address the phenomenon of inquiry. Consistent with critical social inquiry, a focus on participatory knowledge acquisition was utilized to allow the nurses voice to manifest from the dialogue. Careful consideration was applied by the researcher when transcribing stories and practice exemplars, to ensure that the participants own language and voice was fully reflected. In keeping with Kim’s critical narrative inquiry process (1999, 2007, 2010), both the researcher and

the participant read the transcribed text, reflected upon it and dialogued against the criteria of each phase (See Appendix G for Critical Narrative Inquiry: Three Phases).

Narrative inquiry uncovered purposive and purposeful action in reference to the participant's values, motives and goals (Eberhart & Peiper, 1994). Journaling was used by the researcher to document reflexive ideas and exemplars with supportive textual excerpts. Renderings from this journaling process were used to identify salient features of the narrative and their relation to each other and the whole as part of the research process. In regards to demonstrating validity, Eberhart and Pieper (1994) state, "Validity is represented in a well-grounded and strong, supportable conclusion" (p. 49). Validity was achieved by the consensus of participants and researcher, as demonstrated by the clarity of transcribed narrative exemplars in the participants' voice. To achieve construct validity, trustworthiness and rigor, every effort was made to maintain methodological procedures as described by Kim (2010, 2012), to ensure the participants' voice and experience was heard and told as each phase of the study evolved over time.

3.4 Participant Selection

Registered professional nurses working on the Oncology unit in an ANCC Magnet[®] re-designated healthcare system in upstate New York were invited to participate in the study using the sampling technique of purposeful snowballing. The purposive snowballing technique seeks a self-selected participant sample based on desired characteristics that match the study constructs (Creswell, 2009). An open invitation flier was posted on the unit to invite nurses to an informational session that described the study. An invitation to participate in the study was given to all Registered Nurses on the Oncology unit who were currently employed at the hospital for at least one year. The written letter of invitation to participate described the study, participant rights

and responsibilities, confidentiality issues and the benefits and risks of participating. Eight participants were recruited based upon meeting study criteria to participate and her/his willingness to commit to the constructs of the study and data analysis in three phases: 1) descriptive, 2) reflective, 3) critical/ emancipatory. The participants were contacted by the researcher (via email and telephone) to schedule the research sessions. All participants worked at the hospital for at least one year, some had exposure to nursing theory and Watson's Theory of Human Caring, participated in patient care (in either a direct or indirect role), and had the ability to impact the nursing culture, care and the practice environment. Participants were given an Integral Nursing Questionnaire to ascertain educational, practice and demographic data at the first dialogue session with the researcher. (See Appendix F for Integral Nursing Questionnaire) Participants consented to meeting with the researcher in person for audio-recorded dialogue sessions lasting approximately one hour, in three sessions, occurring over a period of three months. The participants were interviewed individually in each phase until theoretical saturation was attained. All eight participants who were recruited participated fully and without recidivism.

3.5 Method of Data Collection

St. Peter's Hospital in upstate New York was chosen as the research site because it is an ANCC Magnet[®] re-designated healthcare system with a history of using Watson's Theory of Human Caring to inform its professional nursing practice conceptual model of care. Access to hospital nurses who were invited to participate in the study was gained after Institutional Review Board approval was granted by both The Sage Colleges and St. Peter's Hospital. Nurses on the Oncology Unit who were employed in a full or part-time capacity for at least one year were recruited by the researcher with the support and assistance of the nurse manager by verbal and written invitation. Nurses who were interested in participating were contacted by telephone by

the researcher to discuss the study and requirements. Participants who met the selection criteria and consented were invited to participate in the study and the initial interview date, time and place were arranged. Interviews were conducted in a private conference room on the unit at the hospital for convenience to the participants.

The participants were provided an overview of the research topic by the researcher at the beginning of the first in-person narrative inquiry session and completed an informed consent form with the researcher. The method of data collection was narrative and qualitative in nature, using one on one inquiry-dialogue sessions that were audio recorded by the researcher using an iPhone digital voice recorder, from August through October 2012 at St. Peter's Hospital in a private conference room. Participants were given an Integral nursing questionnaire that collected demographic, educational, practice and self-care data at the first session (See Appendix F for Integral Nursing Questionnaire). Data collection proceeded according to Kim's (1999, 2007, 2010) critical narrative method until theoretical saturation was met. To prepare participants to tell their stories with a beginning, middle and end that answered the research questions, the researcher provided participants information that explained the background, terminology and dialogue questions (See Appendix G for Critical Narrative Inquiry: Three Phases) at the first session and referenced it at each subsequent session.

Data collection proceeded in a total of three private individual sessions lasting 30 to 60 minutes each, until theoretical saturation was met for each phase by each participant. The three phases of critical narrative inquiry as described and clarified by Dr. Kim (personal correspondence, 2012) are: 1) Descriptive: participants told their story with a beginning, middle and end that reflected their experience of using Human Caring in their practice. Focus was on how participants were impacted by theory guided practice and how nursing qua nursing

manifested in their individual roles; 2) Reflective: participants reflected on their stories against the espoused theories of Human Caring, Integral Nursing and critical social theory, and dialogued with the researcher regarding how their stories reflected theory in action, and how they demonstrated comportment and self-agency in their practice; and 3) Critical- emancipatory: participants identified changes and transformations that occurred and that they would like to achieve (personal, professional, ethical, sociopolitical, metaphysical, spiritual) through the process of transformative learning and critical narrative inquiry.

The third and final dialogue session gave clarification and closure to the data collection process with a focus on the emancipatory praxis of integral nursing. Audio data from the iPhone digital voice recordings were transferred to the researchers secure computer as MPEG3 files and copied into the NVivo 10 qualitative software program. The audio data were then transcribed into text by the researcher using the NVivo 10 qualitative software program and kept on a secure, password protected hard drive. Written transcript data were shared with the individual participants by electronic mail via private, password protected, secure system computers from August through November 2012.

Each participant's transcripts were collated into one document with three phases and assigned a unique identification number by the researcher. All final collated data were sent to participants by electronic mail by the researcher for final verification. Transcripts were used for research and scholarly purposes only, and all data were de-identified using numeric acronyms by the researcher prior to dissemination and publication. Dissemination and publications of the findings may be presented to relevant peer-reviewed journals and at professional conferences, to which all participants consented.

3.6 Role of the Researcher

The role of the researcher was to share power with, and facilitate reflective narration with participants so that exemplar cases of using the Theory of Human Caring in practice were elucidated (Kim, 1999, 2007, 2010). The researcher sought answers to the research questions by conducting a narrative inquiry of story, and engaging in dialogue with participants regarding the facilitators and barriers to structural empowerment, control over nursing practice, and the nurses' experience of the emancipatory praxis of integral nursing. The researcher had the deontology to protect the participant's anonymity and bring forth the participants voice in her/ his stories. This process empowered participants and generated knowledge of nursing practice and the impact of a theoretically guided caring-healing nursing qua nursing milieu.

To remain true to the emancipatory praxis, critical, feminist social theory paradigm, the researcher utilized a Peace and Power process in all encounters with participants. The Peace and Power process is described by Chinn (2008) as praxis, empowerment, awareness, cooperation and evolvment.

Chinn states,

Praxis is thoughtful reflection and action that occur in synchrony...values made visible through deliberate action. Empowerment is growth of personal strength, power, and ability to enact one's own will and love for self in the context of love and respect for others. This represents a partnership, power with approach to self, others and environment. Awareness is an active, growing knowledge of self and others and the world in which one lives. This means tuning in to the moment and valuing one's own experience. Awareness requires integration of past, present and future that is unfolding, and evaluating experience for social, cultural and structural barriers. Cooperation is an active commitment to group solidarity and group integrity...grows out of mutually defined values, where each individual's viewpoint and abilities are honored equally. Cooperation generates unity and recognizes the unique talents, thoughts and contributions of each person that benefit the group as a whole. Evolvment is a commitment to growth where change and transformation are conscious and deliberate...one creates opportunities as she/he lives them...there can be no mistakes...only opportunities for re-creation. Evolvment of a group reflects shared heritage and experience over time and space,

reflective of transformation and growth that naturally occurs over time (Chinn, 2008, pp.10-12).

In addition, the researcher formed a solidarity group with her participants by adhering to the caring-healing-power with partnership constructs of Cultural Transformation Theory (Eisler, 2010). The role of the researcher was to create a safe space for participant's to tell their stories, reflect, dialogue and imagine the possibilities for transformative change, enhanced self-agency, comportment and a refined emancipatory praxis of integral nursing.

3.7 Limitations and Bias

Limitations of the study may be that findings are not transferable to other hospitals as each hospital has its own culture and elements of structural empowerment. Even within the hospital itself, results may not be transferable from unit to unit due to diverse subcultures within the hospital culture. Another limitation is this is a single site study based on nurses self-reporting of narrative experience which is subjective to the participants' notion of reality, which is largely normative and influenced by preset mores. The majority of nurses (~55%) at St. Peter's Hospital is educated at the Associate Degree level and have had minimal or no exposure to theory guided practice, the Theory of Human Caring, and the metaparadigm and metalanguage concepts of Integral Nursing and partnership social systems. The nurses had limited knowledge of ANCC Magnet[®] and the constructs of their professional practice model and structural empowerment processes. Another potential consideration was the change that participant nurses experienced as a result of the critical narrative inquiry process and their potential discontent with the status quo, thereby potentially generating internal chaos and conflict as new patterns formed and emerged for them.

3.8 Data Analysis

Data analysis in an emancipatory study is conducted by the researcher and participants in a manner that supports the full expression of the participant's voice to demonstrate theory in practice and action (Argyris & Schon, 1974; Schon, 1991; Kim 1999, 2007, 2010; Chinn, 2008). Data from the sessions were collected and analyzed using narrative analysis based on Kim's method of critical narrative inquiry in three distinct phases: descriptive, reflective and critical/emancipatory. In the descriptive data analysis phase, after the nurse participant described a story of recent practice events and circumstances, including her/his actions, thoughts and feelings; the recorded story was transcribed by the researcher using NVivo 10 software. This phase entailed the scripting of the nurses' specific case or situation where Human Caring Theory guided her/his practice and experience of caring-healing. According to Kim (2012) this may be done by the nurse writing or telling the story to the researcher. In this study the researcher received the story verbally from the participant and audio-recorded it using an iPhone digital recorder. The written narrative data of stories from the nurses' voice and perspective were then read and analyzed by the researcher who developed practice exemplars from the data to answer the research questions. Attention was given to descriptions of genuineness and comprehensiveness, resulting in a descriptive narrative product. The researcher's focus was to analyze the story and write practice exemplars from the stories which reflect the nurses' voice and rich description of experience.

In the reflective phase of data analysis, the descriptive practice exemplars from phase one were sent via electronic mail to each participant prior to the next scheduled meeting. The participant and researcher each read, reflected and dialogued about the exemplars, thereby conducting a reflective analysis in three parts: 1) against the espoused theories of Critical Social, Human Caring and Integral Nursing; 2) on the case or situation described; and 3) on the nurses

intentions in the exemplar (Kim 2010, 2012). The researcher and participant met to dialogue about the reflective analysis which was audio-recorded and transcribed by the researcher using NVivo 10 qualitative software. The researcher analyzed the transcribed data and wrote narrative exemplars of the nurse's theoretically based practice, including her/ his manifestation and awareness of nursing qua nursing, and how her/ his comportment and self- agency were reflected in the process. This reflective phase data resulted in a knowledge product of the practice processes, and applications of the nurse awareness of her/ his self-agency.

In the critical/emancipatory phase, the reflective dialogue exemplars were sent electronically to the participants before the third and last scheduled interview session. The researcher and participants read, reflected and dialogued focusing on a critique of practice exemplar regarding conflicts, distortions and inconsistencies that manifested in the reflective phase, engaging in an emancipatory change process. The emancipatory change process resulted in a transformational learning experience for participants, as participants contemplated her/ his ability to change social behavior and practice (Kim, 1999, 2007, 2010).

The critical narrative inquiry process was reviewed with participants at the beginning of the study, at the beginning of each session and at the end of the study to ensure rigor (See Appendix G for Critical Narrative Inquiry: Three Phases). All dialogue data were audio-taped and transcribed by the researcher using NVivo10 qualitative software. Final summary data from all three phases of the critical narrative inquiry process were sent to each participant and member checked for final rigor, clarification and validity.

Summary of Research Method

This research study conducted a critical narrative inquiry into the impact of theory-guided practice with nurses who work in an ANCC Magnet[®] re-designated healthcare system in

New York State. The purpose of the study was to understand the facilitators and barriers to the emancipatory praxis of integral nursing qua nursing as informed by Watson's Theory of Human Caring. Structural empowerment in ANCC Magnet[®] hospitals purports to support nurses at organizational and educational levels, but findings in the literature suggest nurses may be disempowered and lack control over their practice due to the suppression of nursing qua nursing by the dominator social systems of medicine and managerialism, possibly even in ANCC Magnet[®] designated hospitals (Beck, 2006; Clark, 2010). This study aimed to understand the nurse's emancipatory experience at one ANCC Magnet[®] re-designated healthcare system. The results of this study provided new information that contributes to the emancipatory praxis of integral nursing as informed by Human Caring Theory guided practice in one ANCC Magnet[®] re-designated healthcare system.

Chapter Four presents the research findings of this study. Demographic data from the integral nursing questionnaire and critical narrative inquiry data were utilized to answer the study's research questions. The research findings are presented in the following format; descriptive summary data from the questionnaire, followed by answers to each of the research questions with narrative exemplars, summary of findings of the narrative data and adherence to scientific rigor.

Chapter Four

4. Research Findings

This chapter presents the research findings of this study. The purpose of this research was to determine the impact of Human Caring Theory (Watson, 2012) guided practice upon nursing qua nursing in an American Nurses Credentialing Center's (ANCC) Magnet[®] re-designated healthcare system. The final sample included eight ($N=8$) nurses who were employed greater than one year on the Oncology unit at an ANCC Magnet[®] re-designated healthcare system in Upstate New York, and who were interviewed in-person, at the Hospital in a private conference room at mutually convenient times. Four ($N=4$) nurses participated during work hours, two ($N=2$) before work and two ($N=2$) on their day off. The nurse manager supported the study by assisting with nurse enrollment and ensuring coverage for staff who participated during work hours.

The study was conducted in two parts: 1) a demographic questionnaire was created by the researcher and completed by the participants. The questionnaire data describes the participants' demographics related to age, ethnicity, academic education, education to nursing theory including the nursing metaparadigm of nurse, person, health and environments and to Watson's Theory of Human Caring, years of experience as a registered nurse and years of experience on current nursing unit, education to integral-holistic health and use of complementary and alternative modalities in nursing practice, and in their own self-care; and 2) Participant verified data from the critical narrative inquiry process were used to answer the research questions.

Kim's (2010) qualitative methodology of critical narrative inquiry was used to conduct this study. The researcher met with participants at three separate times, in three separate and contiguous phases (descriptive, reflective and critical/ emancipatory) to answer the following

research questions: 1) What are the emancipatory experiences of nurses in a Magnet[®] re-designated healthcare system that promotes Human Caring Theory; 2) What are the patterns that facilitate nurses' comportment and self-agency to fully embody and practice integral nursing qua nursing in a Magnet[®] re-designated healthcare system; 3) What are the patterns that create barriers to nurses' comportment and self-agency to fully embody and practice integral nursing qua nursing in a Magnet[®] re-designated healthcare system; and 4) How does the organization support nurses control over their nursing practice within this one ANCC Magnet[®] re-designated healthcare system?

Results of the study indicated that the majority of nurses ($N=6$) were prepared at the Associates Degree level, and half ($N=4$) were pursuing advanced academic education, supported by the Magnet[®] re-designated healthcare system and Oncology unit nurse manager with paid time off and flexible scheduling to meet the demands of academic education. Although the majority of the nurses ($N=6$) did not report any prior education specific to Watson's Theory of Human Caring, the critical narrative inquiry process helped all of the participants ($N=8$) to identify that they were using many elements of the theories of Human Caring (Watson, 2012) and Integral Nursing (Dossey, 2008) in their nursing practice and self-care.

4.1 The Participants

Participants were recruited by invitation via an in person introductory educational session on the nursing unit and by recommendation of the nurse manager for those whom could not attend the introductory session. The introductory session was held at three separate times on one day, so that day, evening and night staff could participate. During the introductory sessions, the researcher asked potential participants to sign in, provide contact information and identify their interest as: 1) yes, interested; 2) may be interested, tell me more; and 3) not interested.

The researcher verbally described the study to potential participants and provided an educational packet that included the letter to participants, informed consent and a general overview of the study. Of 13 potential participants, 10 volunteered, and two were not qualified to participate due to a lack of registered nursing experience greater than one year. Thus, eight ($N=8$) registered nurses, working at the staff level on an inpatient Oncology unit, in a Magnet[®] re-designated hospital located in an urban upstate New York region formed the study sample.

All eight ($N=8$) study participants met with the researcher on three separate occasions in a private conference room at the hospital where narrative interviews were conducted using Kim's criteria (2012). More specifically, written informed consent, including permission to audiotape, and a written Integral Nursing survey were conducted at the beginning of the first interview session. The survey data were described both narratively and using descriptive statistics, including demographic data. The narrative data were transcribed, analyzed and verified by participants following each phase of the study and upon completion. Survey and narrative data were subsequently used to answer the research questions for this study.

4.2 The Integral Nursing Questionnaire

Demographics

Participants in the final sample ($N=8$) included seven ($N=7$) females and one ($N=1$) male. The median age was 40.5 years with a range from 25 to 62 years. Regarding ethnicity, 50% ($N=4$) of participants reported being Caucasian, 12.5% ($N=1$) Hispanic, 12.5% ($N=1$) Asian, 12.5% ($N=1$) Asian-Indian and 12.5% ($N=1$) African American. Regarding level of education, 62.5% ($N=5$) of participants reported having an Associate Degree in Nursing, 25% ($N=2$) had a Bachelor degrees in nursing; and 12.5% ($N=1$) had a Diploma in nursing. Regarding furthering their education, 32.5% ($N=3$) of participants reported being enrolled in a Bachelor of Nursing

degree program, while 12.5% ($N=1$) were enrolled in a Master of Nursing degree program at the time of the study. None of the participants held a Master degree in nursing. Years of nursing experience ranged from 1.5 to 17 with an average of 5.6. Years of nursing experience on the Oncology Unit at the hospital ranged from 1 to 10 years with an average of 4.9 years.

Table 1 describes participant demographics related to gender, age, ethnicity, academic education and years of experience.

Table 1

<i>Participant Demographics</i>		
Gender:	Female ($N=7$)	Male ($N=1$)
Age:	Median 40.5 years	Range 25-62 years
Ethnicity:	50% ($N=4$) Caucasian	
	12.5% ($N=1$) Hispanic	12.5% ($N=1$) Asian
	12.5% ($N=1$) African American	12.5% ($N=1$) Asian-Indian
<i>Current Level of Academic Education:</i>		
	62.5% ($N=5$) Associate Degree in Nursing	
	25% ($N=2$) Bachelor Degree in Nursing	
	12.5% ($N=1$) Diploma in Nursing	
<i>Level of Academic Education Currently Enrolled:</i>		
	Bachelor of Nursing degree program	32.5% ($N=3$)
	Master of Nursing degree program	12.5% ($N=1$)
Total Years of Nursing Experience:	Average 5.6 years	Range 1.5 to 17 years
Years of Nursing Experience in Oncology Unit:	Average 4.9 years	Range 1 to 10 years

Education Related to Theory

In relation to formal education of nursing theory, 12.5% ($N=1$) of the participants reported no experience. Regarding some basic education in theory, 37.5% ($N=3$) of the participants reported having some basic education in their Associate Degree program, while 50% ($N=4$) reported having education to nursing theory in their Bachelor's Degree program. Regarding education specific to Watson's Theory, 12.5% ($N=1$) of participants reported never

having any education related to Watson's Theory, 37.5% ($N=3$) reported some basic education related Watson's Theory, and 50% ($N=4$) of nurses reported having more in depth education related to Watson's Theory, as well as exposure to other nursing theories including King, Orem, Roy, Rogers and Newman. All education to theory was from the academic arena. No hospital based initial or continuing education to theory or theory-guided practice was reported by the participants.

Table 2 describes nurse participants' reports of education to nursing theory in their academic nursing programs.

Table 2

<i>Education Related to Nursing Theory in Academic Nursing Program</i>	
No Education:	12.5% ($N=1$)
Associate Degree Program:	37.5% ($N=3$) Reported "some"
Bachelor Degree program:	50% ($N=4$) Reported "more"

Table 3 describes participant's reports of education to Watson's Theory of Human Caring in their academic programs.

Table 3

<i>Academic Education Related to Watson's Theory of Human Caring</i>	
No education:	12.5% ($N=1$)
Some education:	37.5% ($N=3$)
More Education:	50% ($N=4$)

Holistic, Complementary and Alternative Nursing Practice

One ($N=1$) participant reported learning about holistic nursing in her nurses training in India; while 87.5% ($N=7$) reported being trained in the United States and denied having education to holistic nursing and complementary health modalities. All of the participants, except

one nurse, 87.5% ($N=7$) in the study reported using Complementary and Alternative health Modalities (CAM) in their practice. Regarding referrals for CAM therapy and spiritual care consults, 37.5% ($N=3$) of participants reported regularly such referrals. All the participants except one nurse, 87.5% ($N=7$) reported using CAM for self-care. CAM modalities reported as being used by the nurses in nursing care were: humor, music and guided imagery on the C.A.R.E. channel, relaxation, healing touch, therapeutic touch, Reiki, prayer, holistic health counseling, authentic presencing and creating a calm, caring, healing environment. CAM modalities used in self-care include yoga, Ayurveda, Eastern medicine including herbs and acupuncture, prayer, massage, music, humor and health counseling with nurse colleagues. Cultural influences toward CAM were reported from Asian-Indian and Asian participants to include yoga, Ayurveda and prayer from the Asian-Indian participant and Eastern medicine and acupuncture from the Asian participant. Religious affiliation to the Catholic religion and the importance of prayer and spiritual practices including the use of religious artifacts was reported from 25% ($N=2$) of the participants.

Table 4 describes participants' reports of their education and use of Holistic Nursing and Complementary-Alternative Modalities (CAM) in practice and self-care.

Table 4

Holistic Nursing and Complementary-Alternative Modalities (CAM) in Nursing

No Education to Holistic Nursing and CAM:	87.5% ($N=7$)
Some Education Holistic Nursing and CAM:	12.5% ($N=1$)
Holistic Nursing and CAM use in Practice:	37.5% ($N=3$)
Request Referrals for CAM Therapy for their Patients:	37.5% ($N=3$)
Holistic Nursing and CAM use in Self-Care:	87.5% ($N=7$)

CAM used in Practice: Humor, Music, Guided Imagery on the C.A.R.E. channel, Relaxation, Healing Touch, Therapeutic Touch, Reiki, Prayer, Holistic Health Counseling, Authentic Presencing, Creating a Calm-Caring, Healing Environment

CAM used in Self-Care: Yoga, Ayurveda, Eastern Medicine including herbs, Acupuncture,

4.3 Research Questions

The critical narrative inquiry process generated data that addressed the four research questions identified in this study. The following section will present each research question and then provide narrative data analysis to substantiate responses to each question. Patterns that are presented in this section are those that occurred most frequently in the participants narratives. All narrative data were read individually and collectively as a whole to identify common patterns that emerged. Individual participant narratives are presented to contextualize the data in the nurses' voice.

Research Question 1:

What are the emancipatory experiences of nurses in a Magnet[®] re-designated healthcare system that promotes Human Caring Theory?

Emancipatory Praxis

Emancipatory praxis is the process of freedom, empowerment, growth, development and enlightenment that results from transformational learning. Nurses described their embodiment of theory guided practice as they evaluated and acted upon internal and external environments to facilitate health and healing for their patients and for themselves. The emancipatory experiences of nurses as they promote Human Caring as described by nurses in this study are: 1) nurses established a caring-healing relationship with their patients and families; 2) nurses fostered their patients authentic expression of positive and negative feelings; 3) nurses helped patients to meet their integral health needs; 4) nurses promoted teaching and learning to help patients and families understand their health conditions and helped them to make informed healthcare choices and decisions that resonated with what was right for the individual; 5) nurses allowed for and

recognized miracles, and met their patient's spiritual needs; and 6) nurses used their voice to uphold ethical and moral choices to do the right thing for their patients by sharing power with the patients and their families in the healthcare system. The participants came to realize they were using the Theory of Human Caring in their practice, self-care and care for other nurses and team members as their understanding of emancipatory praxis evolved through the critical narrative inquiry process.

Voice of Nursing

Participant 4 reported, "I feel I have the power to say what is best for my patient and their family. I establish a rapport and build on it, it's how I do my job and get the best outcomes for my patients and their families. I am respected by doctors and the other members of the team, they listen to me." Participant 7 said, "I listen to them (patients and families) and find out what they want and need, and we go from there. I teach them about their health and the options they have, and help them to make decisions that are right for them. Then I tell the rest of the team what they want and need." Participant 6 reported, "I have a lot of power in my role to create change. I want to help other nurses to do the right thing and care the way they ought to care and the way they want to care for patients and for each other."

Participant 5 said, "Nursing is about being a humanitarian and doing what is right and good for our patients and ourselves. Nursing is so much more than the tasks we do. I am here for the patient and the family. The family feels like they have to be in charge of everything and they carry a lot of burden for our patients. I try to help them get what they need. I have their backs so to speak; I hold them all up and watch out for them." She also said, "You develop a filing cabinet of experiences of how to work with people and are successful in the profession. It is about how we treat each other; I think the theory is about taking care of myself and other nurses too."

In these exemplars, the nurses described how they used their voice in the healthcare team to make a difference in how care is provided to patients on the unit.

Advocate for Healing

Nurses reported one of their main foci as advocating for the patient and family in the healthcare milieu. They advocate for the care that the patient is receiving, the care that they need, and the care that they want with other members of the healthcare team. The nurses' help to facilitate the "right relationship" or healing as defined and clarified by the patient and their family. Right relationship is influenced by cultural values, health practices and beliefs. An example of this is reflected in Participant 3's exemplar: She said, "My patient was not eating, her diet was clear liquids, so I asked her what could I do to help her eat. She said I don't eat because I don't like it, there is no flavor." The nurse identified that the patient and her family were Greek and the family was distraught about the mother (patient) not eating and asked the family if they wanted to bring the clear liquids in to their mother. The patient (mother) lit up and the family was happy to participate in their mothers care. She said the patient started eating once the family brought in broth from home. This story exemplified how the nurse advocated for the patient and family healing, and formulated the right relationship to meet both patient and family needs.

In another story, Participant 1 described how she advocated for her patients spiritual healing. She said, "My patient was struggling for air, nothing could make her comfortable and she could not decide on advance directives. I knew she was spiritual by the religious artifacts and cards in her room. So I asked for the Sisters to come and pray for her. The Sisters came with a beautiful pink prayer blanket and covered the patient with the blanket. She had us (the nurse and other care team members who were present) hold hands in a circle around her bed and we prayed together with her. The patient was so comforted by this, she lit up and it made all the difference.

When days of talking about options and educating about care and treatment could not help her to make her decisions, this one moment helped her to see what she needed to do. She accepted the end of life decisions and made her peace. Everything changed from that moment forward.”

Participant 1 described her feelings about caring for the spiritual needs of her patient; she said “After I told her every day that machines could not help anymore, she needed the spiritual engagement to accept her disease and diagnosis. I cried, I didn’t want my happy tears to be confused for sad so I stepped out of the room. It was a pivotal moment, she was in her glory for that short time, she needed it, we all needed it...When people are suffering you really question yourself and ask around to see what else can be done. It’s not just the patient, it’s the family members, they have to watch the patient suffer too. I take care of myself by crying, it is a release, I let it out, it can be toxic if I don’t. As a nurse you try to get the big picture and do what is right.”

Participant 1 also said, “Nursing is not easy by any means. You can’t fix everybody, and no matter how much you try and do for your patients, not everybody appreciates it either. It’s really upsetting when patients don’t appreciate what you are trying to do for them. That’s really upsetting when you are trying to make them comfortable, and give them or find for them or seek out for them what they need and want. When they say that’s not good enough, in those situations I want to cry too, when you feel like you are doing everything you can and you are not able to get through to that person.” The participants described their dedication to health advocacy as a salient part of their role; Participant 6 said, “If we are not doing this for the people than what are we doing this for?”

Creating Healthy, Healing Relationships

Nurses reported feeling emancipated, and helping their patients and families feel emancipated by creating caring-healing and healthy relationships with patients, families and co-workers. They reported the importance of starting the shift by setting the tone of team work and collaboration with colleagues; and by being open and non-judgmental to learning who the patient is as a person, despite any preconceived notions that are passed on in report by other nurses. Nurses in the study discussed the value of establishing and developing their relationships in order to facilitate health and healing.

Participant 8 told a story of how she initiated and conducted a caring-healing relationship with a patient that the other nurses did not want to care for because she was “difficult”. She said, “Nobody wanted to take care of this patient because she was mean to everyone. I had not met her yet, so I said, ‘I will take care of her’. I went in and introduced myself. I told her that I wanted to take care of her the way that she wanted me to. She liked that I approached her that way. I noticed she had prayer cards and religious artifacts around her. So when I went to hang the chemo, I paused and asked her if she wanted to pray with me that the chemo would help her and everything would go well during our time together. She did, and was so happy and grateful that I included her in that way. It was so easy to do and it meant so much to her. She asked for me every time she came in to the hospital after that.”

Initiating and conducting a caring-healing relationship was a pattern that was consistent with all participants in this study. Another example of this is told by Participant 5 who said, “I always go in and introduce myself right away at the beginning of the shift. I want to get to know who my patients are and what they need. It makes the shift go more smoothly. I also want to know who I am working with and it always goes better if we know and respect each other, and

work well together. You have to develop trust. I tell them what I am going to do and when I am going to do it. I keep my word.”

Biogenesis and Salutogenesis

There is a shared sense and focus of integral health in the participants’ stories as they described biogenic (positive, caring-healing approach) and salutogenic (partnering for health) comportment and self-agency in their relationships with co-workers and patients/families. Participant 7 told a story that demonstrated her understanding of partnering to promote integral health and healing relationships. She said, “These are my people. I take my work very seriously and want to take care of my people. I try to find out who they are beyond the illness. I want to know them as people with a whole story that begins, and hopefully ends, somewhere other than here. My job is to take care of them the way they want me to, so I tell them that and we go from there. It is easier to follow another nurse who works like me. One who gives the whole story, not just the basics of heart and lung sounds, diet and meds, one who sees the whole picture and provides whole person care.” Nurses in this study reported using an ethical, moral, and participatory approach to caring for patients and families. They viewed their role as health facilitator for patients and families in the healthcare system. They also reflected upon and discussed their own health and power by expressing how they take care of themselves and each other by using CAM, and elements of the Theory of Human Caring.

Nurses in the study reported emancipatory experiences and used concepts associated with Watson’s Theory of Human Caring, even if they did not have specific education to the theory prior to the study. Nurses embraced the nursing metaparadigm of nurse, person, health and environments (internal and external). The nurses talked about the external environment of the patient’s room as belonging to the patient. They reported when they enter the patient’s room,

they view it as the patient's space that should be honored and respected for how the patient wants her/ his space to be. They said they always knock or announce their entry into the room, asked before moving something and ask if the patient wants to be repositioned, have the C.A.R.E. channel turned on, and lights or temperature changed in the room. They reported that they made suggestions but did not demand that the patient or family do things as they suggested.

The nurses in the study were able to identify the following 10 Caritas Processes (Inova/Watson, 2007) in reflections upon their stories:

1. Embrace altruistic values and Practice loving kindness with self and others.

“The very first this I do is introduce myself and tell them I am here for them. I leave all negative things that other nurses told me about them at the door and enter as if we are both good people, just meeting for the first time.”

“Sometimes I just have to cry, let that emotional release come. It helps me. We see so much suffering. There is always someone to give you a hug when you need it here.”

2. Instill faith and hope and honor others.

“I treat them as I want to be treated, with respect. I try to give them hope and honor their healthcare choices. I don't give false hope though, but there can always be faith. Whatever is meant to be will be.”

“I believed in her, that she could make better health choices if she wanted to. I think it's important to let people know that you believe in them.”

3. Be sensitive to self and others by nurturing individual beliefs and practices.

“She wasn't eating, so I asked her why. She said she did not like what we were giving her. So I asked her what she wanted. She wanted her own homemade broth from

home. She was Greek and she had a big family. So we asked her family to bring her broth from home. It made them happy and she ate it.”

“I believe in acupuncture and Eastern medicine. But people here do not know what it is and how it can help them. I think if they knew, they might want to use it.”

“I have a lot of nurse friends and we talk nurse talk. It helps to have that outlet and support.”

4. Develop helping -trusting- caring relationships.

“I had a new patient who was elderly and scared. So I went over to her, sat down by the bed, and held her hand. I told her I would be with her all night and that she wasn’t alone. I parked my computer cart outside her room and kept my promise even though I had other patients. I wanted her to know that I was there for her.”

“We help each other as nurses here. It’s important to support and mentor each other.”

5. Promote and accept positive and negative feelings as you authentically listen to another’s story.

“There was a patient that nobody wanted to take care of because she was perceived as being difficult. So I said I will take care of her. I went in and introduced myself and said to her, I want to take care of you the way that you want me to. I noticed she was very hardened at first and after I said that she softened. She was very religious, so I asked her if I could pray with her, that the chemo treatment would go well and help her. She was very thankful and I took care of her often after that. She told me she was scared because she was very sick and too young to die. I think that is why she gave the others a hard time.”

6. Use creative scientific problem-solving methods for caring decision making.

“I had a patient who was restless and could not sleep. So I put the C.A.R.E. channel on and gave him his medicine. I turned down the lights and we got him positioned in the recliner in a comfortable position. Then I told him to listen to the nice music and look at the nature images while the medicine started to work, because it would help. Within a short while he was calm and resting.”

“I had a patient the doctor wanted to send home. But she was not ready and did not want to go home to die because her daughter and grandson lived there and she did not want them to remember her dying in their house. So I stalled the discharge and told them that she was not ready. We made a new plan for her to go to the hospice unit, which is where she went. It is important to listen to what they want and give it to them if you can. Sometimes you just have to be a little creative about it.”

7. Share teaching and learning that addresses the individual needs and comprehension styles.

“I had a patient who was admitted for leg pain and it turned out to be advanced metastatic disease. He had just retired and was in his early 60s. His wife was in denial, she was a few years younger than him. So I bought her a cup of coffee and we sat down and talked. He was in so much pain, but he wanted to make sure she was ok. They had so much thrown at them at once. So I went over their treatment options and told them to think about it. She asked me what I would do if it was me. I told her that it wasn't my decision, it was their decision and they had to do what felt right to them. They had the

surgeon telling them to get surgery, the oncologist telling them to get chemo, and another doctor came in and told them to start making end of life plans. They did not know what to do. I just listened and kept asking them to think about what felt right for them. They decided to get another opinion and enter a clinical trial. He felt like it was important to try to help someone else through the trial even if it was too late to help him, and it bought him time to be with his wife and help her to accept his disease.”

8. Create a healing environment for the physical and spiritual self which respects human dignity.

“I encourage my patients to make their room their space. Whatever that they want that makes it right for them. Maybe it’s their favorite music, iPad, computer, pictures, cards, blanket...for the time that they are here it is their space and I respect that.”

“I ask for Complementary therapy, Pastoral care and Palliative care consults for my patients when the signs are there, or if they ask, and sometimes I ask them.”

“When I see that they are religious I ask them if they want me to pray with them.”

“I love the tradition of tucking my patients in at night. I make sure they get their pm care and a backrub, and that they are comfortable before I leave them.”

9. Assist with basic physical, emotional, and spiritual human needs.

“I use humor a lot. It’s a way of connecting that puts everyone at ease.”

“I advocate for my patient’s needs. I try to find out what they need and want and get that for them.”

“I use touch and the tone of my voice to soothe my patients. I am a very positive person and bring that energy with me wherever I go. I help my co-workers as much as I can and they help me.”

10. Open to mystery and allow miracles to enter (Inova/Watson, 2007).

“I had a patient who was suffering, she could not breathe and there was nothing we could do for her, but she was not ready to make her end of life decisions. So one day the Sister came with a beautiful prayer shawl and gave it to her. She had us hold hands in a circle around her bed and we prayed with her. The patients face just lit up and she had peace for the first time in a long time. She was able to make her decisions after that. I was so moved by that experience. I will never forget it.”

Integral Health

Concepts of Integral Nursing that facilitated healing via multiple patterns of knowing and adaptation of internal and external environments to optimize health and complex systems were expressed by participants in their narratives. Participant 4 described how she adapted the external environment to support her patients’ internal environment to promote comfort and rest. She noticed her elderly patient was not able to get comfortable in the bed at night, so she suggested she get out of bed to the recliner. She asked her if she wanted to watch and listen to the C.A.R.E. channel because it has soothing music and nice pictures of nature which might help her drift off to sleep. The patient agreed and the patient slept through the rest of the night comfortably.

Nurse participants also talked about using humor, touch, being present, listening, supporting, repositioning, talking gently, and using soothing and respectful approaches that honored the person; thereby helping patients and their families feel comfortable, safe and cared for on physical-mental-emotional-social-cultural and spiritual levels. The nurses described their use of voice, advocacy and relationship to promote integral health and healing. Independent nursing actions that promote the integration of multiple ways of knowing, doing and being, facilitate health and healing as nurse partners with patient and family to achieve the right

relationship for the individual. The participants unanimously believed that nursing is so much more than only carrying out the physician, nurse practitioner or physician assistant's orders.

The nurses in the study demonstrated through their narratives that caring is sharing power, and partnering with the patient and family to promote integral health and healing. It is through the medium of relationship that nurses use their empowered comportment and self-agency, to help shape and adapt internal and external environments with the goal of healing. Through the critical narrative inquiry process the nurses were able to more fully identify and articulate the independent and collaborative role of nursing as they described, reflected and critiqued their own stories against the constructs of the theories that informed the study.

Research Question 2:

What are the patterns that facilitate nurses' comportment and self-agency to fully embody and practice integral nursing qua nursing in a Magnet® re-designated healthcare system?

Patterns that Facilitate Nursing qua Nursing

The nurses reported patterns that facilitate nursing qua nursing as: 1) establishing and developing helping, healing, caring relationships with patients, families and other care providers; 2) having adequate staffing and reducing task-burden so that nurses have the time to spend in their relationship with patients, families and other care providers; 3) creating and maintaining a supportive culture and environment of care where the voice of nursing as nurse/patient/family health advocate is honored, respected, listened to and acted upon by other team members including managers and providers; and 4) Having the academic and continuing education needed to: a) develop and support an Integral Nursing practice; b) make explicit the nursing values of the caring-healing unitary transformative paradigm and; c) develop integral health knowledge and Human Caring Science behaviors within the nursing unit culture.

Taking Time to Understand and Do the Right Thing

Nurses described facilitators of comportment and self-agency as having the time and support to do their jobs as they see fit. The nurses in the study explained how a nurse chooses to support patients and families to achieve best outcomes through intellectual and behavioral comportment and self-agency. An example of this is from Participant 6 who told a story of how she “dragged her feet” to get the best outcome for one of her patients. She said “I received a doctor’s order to discharge my patient home. I had pressure from the case manager to get everything in order so that the patient could go home. Discharge home with hospice was not what the patient wanted because she did not want to die at home. The patient wanted to die in the hospital because her daughter and grandson lived at her house and she did not want to tarnish it for them. I needed to figure out what to do. So I told the doctor and the case manager that they were not ready for her to go home and bought a few more days. Her daughter and grandson came in everyday to see her. I wanted what was best for them. Her daughter had her hands full and I could see she was not ready or able to care for her mother at home. The discharge plan just was not going to work. So after a few days I talked the doctor and case manager into transferring her to the inpatient hospice unit which we did. It was what was right for them.”

In another example, Participant 8 discussed how she made herself available to a patient from her country who needed her help, but had to accept it on her own terms. She met a patient with advanced metastatic disease who was from her country. The patient was alone and did not have any family in this country. The nurse said she introduced herself and offered to help her to contact her family at home since she spoke the language and knew the customs of the culture. The patient kindly refused until her final re-admission to the hospital when she called for Participant 8 to come to her bedside. Participant 8 then helped the patient to contact her family

and set up the final arrangements for her transition and end of life wishes. She said the family and patient were so grateful for her help. Participant 8 said, “It was the right thing to do, she needed me to help her, but I had to do it on her terms, and in her time, not mine.”

Participant 7 discussed how she demonstrated comportsment and self-agency to help her patient and his wife come to terms with a new devastating diagnosis and make healthcare decisions for treatment that were aligned with their readiness for understanding and their hopes and beliefs. She said, “I came in to work one night to find a man in his early 60s, who just retired, and his wife who were both distraught because he presented to the Emergency room because of belly and leg pain and was told he had advanced cancer everywhere. He had doctors coming in from every specialty and they were totally overwhelmed and devastated by the news. So I got his wife a cup of coffee and we sat down and just talked. I listened to their story of how they got here and who said what and who recommended what. Then I asked them if they understood what they were told and answered their questions. Then they asked me what they should do: chemo, radiation, surgery, or go home. I asked them what they wanted to do. He wanted to go home and think about his options. So that is what we did. It took a few days to convince the doctors, but it was his choice, not theirs.”

Supportive Team Relationships and Education

Facilitators were reported by the nurses as taking the time to do the right thing, and using her/his self-agency to enact the best outcomes for themselves and their patients and families. Nurses felt this involved having a voice in decision making, and the support of team members who respect and listen to them. They also believed facilitators were related to relationships and trust as they use their knowledge, talent and skills to enact outcomes of care that meet the patients and families internal, external, cultural and sociopolitical needs. Educational support

with access to the most current healthcare research, and access to nurse mentors was cited by the nurses as having a positive impact on facilitating their comportment and self-agency of Integral nursing.

Research Question 3:

What are the patterns that create barriers to nurses' comportment and self-agency to fully embody and practice integral nursing qua nursing in a Magnet[®] designated healthcare system?

Patterns that Create Barriers to Nursing qua Nursing

Nurses' reported patterns that create barriers to nursing qua nursing as: 1) a lack of academic and continuing education to the theoretical foundation, language, and power of nursing, especially at the Associate degree level and in the hospital at the unit level; 2) constraints of time and the burden of tasks in the staff nurse role which are further influenced by variables outside of their control (ie: increased acuity and decreased staffing); 3) other nurses who only fulfill the providers orders and needed tasks, and do not fully engage in relationship, health and healthcare choice partnership and advocacy with patients, families and the healthcare team.

Constraints on Time and Task Burden

Nurses reported constraints on time and the constant demand of multiple tasks as barriers to care. They identified the WOW (computers-nurses cart on wheels) as being both a benefit and a burden. Computerized charting takes time and there are many steps to giving medications with the computerized system which they said improves safety, but slows them down in other aspects of providing care. The newer nurse participants in the study with less experience discussed how they felt "like the train was leaving the station and I had to run to catch it all the time" when they were learning how to prioritize and manage multiple "incoming and outgoing demands." They

also identified varying levels of ability and knowledge in support staff. Care technicians (techs) provide most of the physical care to patients, but need guidance, assistance and supervision. Many of the nurses discussed an approach of doing care with the techs at the expense of their other tasks. They discussed the tasks as being a barrier to doing the work of nursing that they want to do, such as sitting down, spending time with and talking, coaching, educating and counseling patients and their families about their health and care.

Need for Educational Support

Other barriers that the nurses identified are a lack of nurse educator support on the unit and the times and modes that are convenient for the nurses on evening and night shifts. None of the nurses said they had seen or had access to the Magnet[®] professional practice model, though one nurse had called the Director of Professional Practice to ask for the information during the study because she was taking a class and wanted to use it for a project. Participant 8 said, “I need to know more about this (Magnet[®]) and how we are supposed to meet it (the standards).” Participant 7 said, “We have not had any education on theory guided practice and Magnet[®]. I can’t participate in shared governance committees because they are all during the day and I work nights.” Participant 4 said, “We need to talk about ideas to infuse this theory into practice and the culture on the unit. We need to have a voice beyond the unit level, where we can talk about what we do and need as nurses so that we can really do our jobs the way we want to.” The nurses also reported a lack of education specific to CAM, and were concerned that even if they learned CAM techniques, they may not have time to use them in their practice because the other demands of the role would take precedence.

All of the participants reported a lack of continuing education on nursing theory, the professional practice model and Magnet[®] standards. They expressed that they did not know what

theory their practice model was based on and did not know what the Caritas factors were before participating in the research study. They all knew that they worked in a Magnet[®] hospital, but did not report having any continuing or hospital based education to Magnet[®]. Overall, the nurses reported that these barriers were not insurmountable, and felt that with education, experience and attention to time management and the support of caring colleagues and techs, they could overcome and manage the barriers that exist in the system.

Moral Conundrum

Participant 6 described the moral dilemma nurses face when the business side of healthcare conflicts with nurse's desire to care. She said, "We are really in a moral conundrum, why does healthcare have to be a business that has to focus on money by giving nurses so many patients to take care of that they feel they can't do what they really want and need to? Just taking care of people is why we keep coming back every day. The patients need our warmth and compassion. It's the people part that caught my eye about this profession."

Research Question 4:

How does the organization support nurses' control over their nursing practice within this one ANCC Magnet[®] re-designated healthcare system?

Control over Nursing Practice

Nurses in this study report the organization supports nurses' control over their practice by: 1) the nurse manager is accessible, supportive and responsive to staff needs, including:

- a) providing the human resources needed (ie: adequate staffing based on acuity, and a resource nurse who is a clinical leader that floats and helps the nurses);
- b) providing flexible scheduling so that nurses can complete advanced education and meet personal life needs;
- c) engaging staff

in, and being open to change; d) carrying their voice and needs to administration, providers and team members; and e) promoting a positive work environment by encouraging partnership, personal-professional growth, and acknowledging staff successes; 2) the organization supports nurses to return to college and achieve advanced levels of nursing education; 3) nurses reported their voice is heard and their advocacy role is respected by patients, families, managers, providers and team members; and 4) the organization promotes a positive image of nursing.

Structural Empowerment

The structure of the unit, the staffing pattern, the manager and the resource nurses were reported as positive facilitators to their practice. The nurses report they have control over their practice and they feel they can go to the manager with any concerns they have. The newer nurses find the experienced nurses approachable and supportive as mentors. An example of this was reported by Participant 3 who said, “When I have a difficult situation and I am not sure how to handle it, there is always someone I can go to who will come with me and I watch how she handles it, and I learn from it.” The nurses report that advanced academic nursing education is fully supported by the hospital and manager. The nurses state the manager helps them with flexible scheduling to accommodate school schedules and family life. They also report getting a tuition stipend from the hospital to help pay for school.

Participant 1 discussed the support she receives from the manager and organization. She said, “I could not go back to school if not for these supports. This is one of the reasons I chose to work here. This unit is structured and run so well that I have the supports I need to do my job. I know that I could go to my manager or resource nurse anytime I needed something, and I would

be heard and supported. That really makes a difference to me as a new nurse who wants to better myself and my practice all the time.”

Power to Create Change

Participant 6 also reported that she had control over her practice and identified factors that support her. She said “I have the power to make change here, and I like that. The manager and I meet and talk about what we can do better all the time. I am heard and my ideas are welcomed and matter. That is important to me at my age. I feel like nursing is about helping people and I feel like I can do that here, not just for the patients and families, but also for the nurses that I work with.” She also said, “The manager supports most things that the staff wants to do. I am empowered by making differences with new staff; and the rewards of empowering others’ feeds me. Even if you only impact one person one way, it makes a difference. It becomes a grassroots movement and makes life rewarding. Your life means something when you impact others in a positive way. I feel I can do that here.”

Methodological Rigor

Methodological rigor was ensured and limitations were addressed by adhering to the constructs of critical narrative inquiry as described by Kim (1999, 2010, 2012). Every effort was made to hear the nurses’ narratives in her/his voice. Narrative data was member checked with each participant in each phase of the study to ensure validity. In this participatory qualitative study design consideration was given to the potential of the nurse researchers’ reflexive influence on participants to report experiences, beliefs and behaviors that support the positive findings of the study and minimize the deficiencies in care that they either participated in or experienced. Efforts made to minimize this limitation and ensure rigor included the nurse

researcher paraphrasing and asking for further data to clarify, verify and amplify the participants' reports of her/his experiences, beliefs and behaviors.

Summary of Research Findings

This critical narrative inquiry, described by nurse participants, was reported to be a transformative learning experience that helped them to see that they were using nursing theory in their practice. It also helped the nurses to identify elements in the culture that support and do not support a theory-guided practice, and gave them insight towards opportunities for self-care. Participants developed their knowledge and expression of the research topic over three sessions with the researcher in a praxiological process of description, reflection and emancipatory change that occurred over a period of three months.

Narrative exemplars, survey data and reflexive notes reveal that although these nurses did not have extensive formal or informal education of the theories of Human Caring and Integral Nursing, they were using components of the theories in their practice. They all stated they wanted to learn more about the theories and how to consciously apply theoretical constructs their practice and self-care. They also wanted to share what they learned with other nurses on the unit at the end of the study and began dialoging with each other and the manager with ideas to create change and infuse the theory into their practices and culture. Some ideas they reported were having a communication board in the nurse's lounge to share ideas on theory guided practice, making t-shirts and visual cue cards with theoretical components and sayings, and having staff meetings and sharing circles to talk about care and practice ideas.

The consensus of the research findings among participants was they gained insight and developed a deeper understanding of what they do and how they do it, nursing qua nursing. The critical narrative inquiry process shed light on those things they did not think about, or reflect

upon, in their day to day care. Participant 8 said, “I am so glad that someone is looking at what we do and valuing it. That means a lot to me.” The nurses’ narratives illuminated their dominant beliefs and behaviors, and helped them to articulate nursing qua nursing. Emancipatory praxis research helps nurses to come to know who they are and how they can use their power both individually and collectively to promote integral health. The process of reflecting upon one’s story sheds light on the consistencies and inconsistencies in human becoming as it relates to a theoretically informed practice. This study identified that nurses are transformative agents. Transformative agency requires the nurse to: 1) see and sense patterns that are emerging and prepare to take and/or take action to harmonize integral health; 2) help patients and their families identify and create change through the embodiment of multiple patterns of knowing, doing and being; and 3) engage in a continual process of self-renewal and emancipatory change.

Opportunities for nursing education and leadership that emerged from the study included: 1) the need to re-evaluate academic curricula and explicitly incorporate nursing theory and an integral health paradigm throughout the continuum, starting at the Associate degree level; 2) the need to provide continuing education to nursing staff at all levels in order to create and support caring-healing environments, and optimal integral health promotion, restoration and maintenance practices for staff, patients and families; 3) individual transformative learning and change occurs with reflection in and upon one’s action, thereby facilitating informed comportment and empowered self-agency through nursing’s voice and advocacy within the healthcare system; and 4) fostering a partnership approach to nursing praxis (theory-practice-research) in the healthcare system creates cultural empowerment for those involved.

Chapter Five will discuss the findings of the research study and address the significance of the findings for nursing education and leadership. It will identify where the findings support and differ from the research literature presented in chapters one and two. It will address study limitations, and conclude with areas for future nursing scholarship and research.

Chapter Five

5. Discussion of Findings

This chapter will discuss the significance of the research findings in relation to the theoretical framework of the current study and identify areas where the research findings align, oppose and provide new knowledge for nursing science, education and leadership. It will conclude with a discussion of opportunities for nursing education and leadership, and ideas for future scholarship including recommendations to advance the emancipatory praxis of Integral Nursing.

Integral Nursing is the grand theory and meta-view of nursing qua nursing (Dossey, 2008; Jarrin, 2012). It is aligned with the unitary-transformative perspective that believes bio-psycho-socio-spiritual health is a dynamic state mediated through complex internal and external environments (Dossey; Jarrin). Emancipation involves the illumination of dominating beliefs and behaviors, followed by a process of applied self-re-creation and renewal (Kim, 2010; Chinn & Kramer, 2011). As nurses gained emancipatory knowledge they were able to see how their thoughts, beliefs and actions create his or her experience as he or she authentically “becomes” in relation to one’s internal and external environments (Parse, 2007). The nurses’ narratives illuminated their dominant beliefs and behaviors, helped them to articulate nursing qua nursing, gained insight into their current practice, and identified practice changes they would like to create. The critical-emancipatory phase helped them to envision an evolved and expanded practice environment that includes the extant integration of Caritas processes and complementary modalities as independent nursing interventions (Inova/Watson, 2007; Watson, 2011; OPSED NYS, 2009; Sparber, 2001).

Emancipatory praxis research helps nurses to come to know who they are and how they can use their power both individually and collectively to promote integral health (Chinn & Kramer, 2011; Kim, 2010). The nurse's role is to facilitate optimal health by providing biogenic (life-giving-healing) care and advocating, counseling and educating patients and families about their health and healthcare choices in a salutogenic (partnership) manner (Dossey, 2008; Halldorsdottir, 1991; Scharmer, 2007). In this paradigm, nursing qua nursing includes and goes beyond the tasks of nursing to an expanded role that addresses the bio-psycho-socio-spiritual needs of persons in a culturally congruent manner through caring-healing relationships. According to Watson (2012) the central focus of nursing is, "those aspects of nursing that potentiate healing processes and relationships, which affect the one caring and the one cared for" (p. 3). The dominant positivist, biotechnical model of care is concerned with curing through the use of biologically focused technology and sections patients into individual parts to be cured. In contrast, holism and integral-holistic nursing aim to assist the patient to integrate parts to the whole body-mind-spirit via the patient-nurse relationship as the vehicle for culturally congruent caring and healing to occur (Davidson, Ray & Turkel, 2011; Leininger & McFarland, 2006). It is the nursing care-context-situation through which the integral-holistic-humanistic nurse facilitates the patients healing experience of unity and transformation to new levels of organization and understanding (Quinn 1992, 2010; Jarrin, 2012). Watson (2012) advises: 1) we must be clear that nursing science is unique for its unitary, cosmological world view; and 2) nursing is grounded in a relational, ethical-moral, human, caring, environment-cosmos metaparadigm. Nurses in this study confirmed these values and conceptual beliefs through their comportment, and salient features of the unitary-transformative metaparadigm were identified in the analysis of their narratives.

This study addressed the gap in the literature related to factors that impact the ideology and empowerment of nursing qua nursing, thereby providing a basis for knowledge development related to the social beliefs that nurses' hold about themselves, each other and the profession. This critical narrative inquiry was described by nurse participants as a transformative learning experience, and helped them to identify that they were using nursing theory intuitively in their practice (Mezirow, 2000; Kim, 2010). It also helped them to ascertain elements in the culture that support and do not support a theory guided practice, and gave them insight towards opportunities for self-care and change. This research aligns with Gregg and Magilvy's (2002) findings that human caring is present in the value system of nursing. The study also confirmed that this Magnet[®] organization provided structural empowerment to nurses and facilitated their control over practice as described by McClure and Hinshaw (2002), the American Nurses Credentialing Center (2008), Kramer and Schmalenberg, (2003) and Kramer et al. (2008); and refuted findings by Beck (2006), McLeland and Williams (2002) and Jacobs et al. (2005) whom found nurses experience marginalization and oppression, and whom did not feel their voice was heard within the healthcare team. In contrast, the nurses in this study felt they had a voice and the power to create the change they wanted to see. They attributed this primarily to their autonomous role as health advocates; and in part to the support of their nurse manager and the participative culture of the nursing unit where nurses are respected for their knowledge and contribution to care.

In the unitary transformative paradigm nurses partner with patients for health by sensing and seeing the multitude of complexities that impact her/him (Quinn et al. 2003). This study is grounded in the unitary-transformative paradigm and concerned with: 1) how the nurse provides care and interacts with patients and their families; 2) how the nurse cares for her/him-self; and 3)

how the nurse cares for her/his relationships with other people and the environments in which she/ he works and lives. Phronesis is practical, context dependent, values-based knowledge that is generated by one's own internal reasoning through a collaborative and collective praxis oriented process. Greenwood and Levin (2008) state this process "involves egalitarian engagement across knowledge systems and diverse experiences" (pp. 67-68). Tsang (2007) describes phronesis as practical wisdom, best gained through a reflective process of shared dialogue with a social group. In this study, the nurse participants belonged to a social group in the Oncology Unit and their individual narratives resulted in emancipatory knowledge that spoke of the heart and soul of nursing as the nurses sought to help, find, provide for and meet the Integral health needs of those entrusted to their care.

It is through phronesis that the nurse sees and senses the patterns that are unfolding which inform her/his comportment and self-agency. Nurses in this study are health advocates who used complementary health modalities to promote comfort and meet the Integral health needs of their patients including: humor, touch, ergodynamic positioning, calm-caring tone of voice, authentic presencing, cognitive-behavioral partnering, health counseling, imagery, music, prayer and spirituality. They reported limited education to these modalities, and a natural ability to utilize them to promote comfort and healing. Perhaps Watson (2012) has the answers to why this occurs and advises that nursing science is unique for its unitary, cosmological world view. Nursing, by its very nature, is grounded in a relational, ethical-moral, human, caring, environment, cosmos metaparadigm (Watson). Theoretically informed unitary-transformative comportment helps nurses establish, develop and maintain caring-healing-empowering relationships with patients, families and care team members (Benner, Kyriakidis & Stannard, 2011).

Complex patterns sensed and seen as they unfold, become the substantive matter of nursing science (Newman, 2002). Findings from this study demonstrate that participant nurses used theoretical elements intuitively, even though they reported limited education to the nursing theory that their professional practice model was based upon. From the notion that theory informs and is informed by nursing praxis, critical narrative inquiry meets the transformative cognitive needs of the nurse as she/he sees nursing qua nursing through story-telling and reflection upon her/his comportment, self-agency, phronesis and emancipation (Kim, 2010; Chinn & Kramer, 2011).

Theoretical Model of the Emancipatory Praxis of Integral Nursing

The study's theoretical framework combined the Human Caring, Integral Nursing, and Critical Social theories for the purpose of Emancipatory Knowledge Development through praxis (See Figure 3 for The Emancipatory Praxis of Integral Nursing Model). The emancipatory praxis of Integral Nursing conceptual model is a blending of paradigms that relate, integrate, support and enhance each other. It provides the nurse with the knowledge; power and language to identify and communicate theoretical constructs in her/his practice and thereby develop an evolved comportment and self-agency of nursing qua nursing. According to Chinn and Kramer (2008, 2011) praxis is "values made visible" and through the process of conscious, thoughtful, theory guided practice nurses express their values, beliefs and behaviors. The theoretical framework of the current study entitled the Emancipatory Praxis of Integral Nursing Model is depicted in the figure below:

THEORETICAL FRAMEWORK FOR THE EMANCIPATORY PRAXIS OF INTEGRAL NURSING MODEL

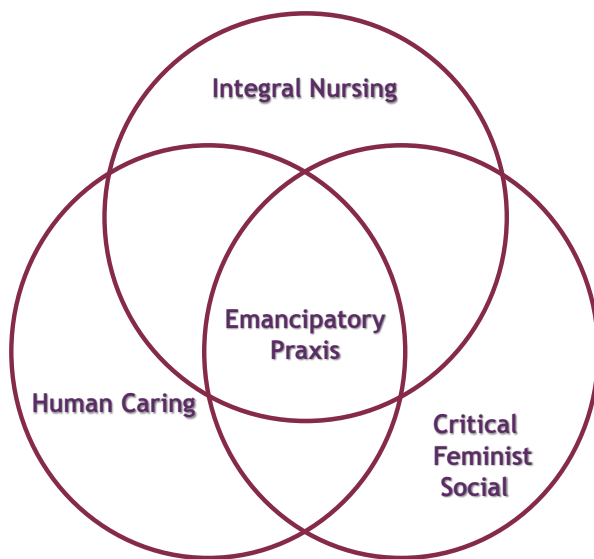


Figure 3: The Emancipatory Praxis of Integral Nursing Model

Integral Nursing

Integral nursing recognizes the complexity, richness and expanded view of health and the human experience. According to Dossey (2008) an “integral worldview enlarges our holistic understanding of body-mind-spirit connections and our knowing, doing and being to more comprehensive and deeper levels (p. 4).” Integral nursing is the broad stroke, grand theory that situates healing at the center core of nursing practice. Healing is impacted by one’s perception of health, human and the internal and external environments that mediate our beliefs, values and behaviors. Dossey (2008) views health and healing as a continuous dynamic state for both nurse and patient. Nurses in this study instinctually agreed with these concepts and their stories validated theoretical components.

Health promotion has opportunities for ongoing self-care and local to global health advocacy (Dossey, 2008). Nurses in this study discussed the importance of advocacy and health counseling in their care. They also identified opportunities to enhance their own self-care and care for other nurses on the unit. Some health advocacy ideas nurses raised for their own self-care included getting more rest, exercise, massage, acupuncture, improving nutrition, having more fun and taking breaks. Integral health is a personally defined dynamic state of knowing, doing and being for each of us as we are constantly learning and adapting to our environments (Dossey, 2008; Jarrin, 2012).

Novel findings from this research include a better understanding of how participant nurses adapted external environments to affect internal environments. Use of complementary health modalities i.e.: music, humor, positioning, prayer... to promote relaxation and rest, partnering with patients and families for health choices, and awareness that the medications they give i.e.: chemotherapy, anti-emetics, narcotics, etc., and nutrition, food and fluids affect the dynamic state of health. Nurses affect these environments with the goal of supporting, restoring or maintain health, achieving an improved state of health or a peaceful and dignified death (OPSED NYS, 2009; Dossey & Keegan, 2010). Nurses in the study discussed how they worked towards facilitating healing for their patients and families, and began to reflect upon their own healing processes in caring for patients and families; which supports Lincoln's (2009) findings of the change that occurs in nurses as they learn about theory guided holistic nursing.

The Theory of Human Caring

According to Watson (2012) the nurse who is informed by a Caritas consciousness embodies a heart centered, caring-authentic presence and sets an energetic intention for the highest healing good for all (nurse, patient, family, universe). Nurses in this study demonstrated

Caritas consciousness and human caring in their narratives with patients, families and each other. They described how they approach their patients (and others) with loving kindness, a non-judgmental attitude, curiosity and respect. They expressed stories that honored the patients' right to make healthcare decisions in the time and manner that is right for them. They described their ways of being with patients and families, including their tone of voice, use of touch, humor, accessibility, tact and openness in clinical and transpersonal situations.

The nurses' stories focused on the independent and collaborative role of nursing as they dialogued about how they practice nursing and how they felt about their practice. For instance, health counseling and advocacy were as significant as using independent nursing interventions to promote comfort and rest. Examples were using the C.A.R.E. channel which included relaxation, imagery, humor, positioning, prayer, intention and obtaining palliative and complementary therapy consults. They discussed advocating for their patient's needs, wants and healthcare choices with providers and case managers. The nature of nursing in this acute care Magnet[®] hospital was not strictly biotechnical in nature, it included biotechnical and unitary-transformative aspects of care. The nurses in the study all believed in miracles and acknowledged the very first thing that they did was to initiate and maintain the human-human connection and hold others in high esteem. In regards to Falk Rafael's (2001) critical question, "What will allow the 'wild nurse' to emerge so that nursing might be actualized within its caring-healing paradigm?" (p. 30). The nurses in this study discussed how their culture supported them to engage their freedom, knowledge, voice and power with the intent of advocating for the healthcare needs and wishes of their patients and families; thereby actualizing an emancipatory, unitary-transformative, caring-healing paradigm.

Although nurses in this study identified a need for continuing education on Human caring, Integral nursing, CAM and theory guided practice, they did not cite difficulty bridging the dominant biomedical model of care to theory guided integral nursing care because theory guided care is infused through and is exhibited in their practice. This study's finding is in contrast to Jacobs et al.'s (2005) and McLeland and Williams (2002) emancipatory praxis study findings where nurses reported feeling marginalized when forced to forego holistic human caring in lieu of dominant biotechnical care; however Jacobs et al.'s and McLeland and Williams studies were not conducted in ANCC Magnet[®] healthcare systems where Watson's Theory of Human Caring informs professional practice. Nurses in this study were not forced to forego holistic human caring; in fact their narratives described integration of this care with the demands of biotechnical care.

Critical Social Theory

The transformative cognitive needs of nurses can be met by using a critical narrative inquiry process of describing a practice scenario, reflecting on the scenario for consistency, inconsistency, and manifestation of theoretical components, and examining the description and reflective dialogue for opportunities to create personal and professional change towards emancipation (Kim, 2010). Merleau Ponty describes the phenomenological primacy of perception and Greene (2007) defines freedom as the imagination of what can be. Nurses in the study used the primacy of their perceptions based on the art and science of nursing, and felt they had the freedom to imagine the best outcome with their patients and families to achieve their goals. Examples they gave were helping a patient make the decisions and take steps to prepare to go home, to go to hospice, to get another opinion, to get a prayer shawl and pray, to have their

environment be their own space, to call their family when they were ready, to have their family bring in their food, to achieve the highest healing good in the situation or context that presented.

Power to create the practice that one wants requires negotiating the system in which one works, and perhaps even negotiating systems that impact the system in which one works such as insurance, regulatory and legislative venues. Although Jacobs et al. (2005), Clark (2005, 2010) and Kagan et al. (2009) found that nurses experience oppression, and may lack the education and skills required to generate emancipatory knowledge and action; the nurses in this study did not express oppression. This may be in part due to the design of the current study which was situated in a Magnet[®] re-designated healthcare system, and the method of critical narrative inquiry which fosters emancipatory knowledge development. The nurses in the current study expressed a need for additional knowledge, education, and skills so that they could feel confident to access these systems.

Nurses in the study reported feeling supported by their manager and felt they could bring any practice changes and concerns to the manager. They believed they would be heard and supported to create change if the larger system allowed; but did not believe that they could negotiate the larger system due to a lack of time, access, education and skill. This finding is consistent with Clark's (2005, 2010) work, in which she advises a refocusing of the nursing curriculum lens to include educating nurses regarding how to negotiate sociopolitical and economic systems for the sake of empowering nurses to embrace the possibilities of further advancement for the profession.

In this study nurses focused on their local influence with patients, other immediate team members and the manager. According to McCabe and Holmes (2009), it is through the process of socio-cultural and academic education, that nurses place themselves in prescribed social

categories and ascribe levels of power to those categories. Nurses in this study ascribed to the socio-cultural power status of the staff and charge nurse role but not beyond; seeing anything beyond that as the role of one with advanced education and standing. They expressed power through voice and entrusted their power to their manager to bring their concerns forward into the system. Time was seen as the biggest barrier to taking on more responsibility for change by all of the nurses. Beck (2006) in her phenomenological study of 12 nurses on a Magnet[®] hospital medical-surgical unit found nurses did not feel their voice was heard, and identified the impact of nurse manager, physician-nurse relationship, staffing, and committee structure upon their ability to have a voice. Nurses in this study felt they had a voice and agreed that voice is linked to autonomy, self-awareness and power (Beck). The nurses did not participate regularly on committees beyond the unit level, though three participants mentioned previous work on hospital wide committees that resulted in a system wide change in practice related to medication safety and fall prevention.

Emancipatory Praxis

Emancipatory praxis research is co-generative in nature, with the researcher keenly aware of the ideal of democracy and equality within the research group. It generates knowledge by raising the research participant's consciousness as insight to the facilitators and barriers of freedom and democracy emerges through the dialogical process (Lather, 1996; Chinn, 2008). The desired outcome of emancipatory research is personal and professional transformation as one consciously evolves with one's world. Transformation is accomplished as the invisible becomes visible to participants through the process of enlightenment. Emancipatory research, which is from the people and for the people, generated knowledge from and for nurses and nursing in this study.

Emancipatory praxis supports nurses in a transformational learning process that helps them to identify salient components of professional practice (Chinn & Kramer, 2011; Kim, 2010). Knowledge that was generated by this study included a deeper understanding of advocacy, relationship, deontology, caring for self and others by supporting healthy behaviors and lifestyles, acknowledging and making space for spiritual practices. In addition, nurses were aware of and either used themselves or sought others to provide non-pharmacologic comfort measures including touch, music, imagery, positioning for comfort, massage, Reiki, healing touch, therapeutic touch, counseling, prayer, respect for and fostering of cultural and personal preferences of patients, families and other team members. These non-pharmacologic modalities demonstrated ways that nurses connected holistically with patients, families and each other. This salient finding is supported by Lincoln's (2009) and Kirkpatrick's (2008) works that support holistic nursing and praxis for relationship based care.

Consistent with Drenkard's (2008) findings, constraints on time and the constant demand of multiple tasks were seen as barriers to providing integral-holistic care, while the support of other care team members, including technicians, doctors, other nurses, mentors and managers were seen as facilitators to optimal integral-holistic care. Positive work team factors included nurses with the same values of caring for the whole person and their families, more than the physical and bio-technical aspects of care. Nurses in the study reported an easier work flow when nurses before, with and after them had the same unitary-transformative value system that views patients and families as a complex dynamic system, in flux due to changes in health; affected by and affecting the mental-emotional-socio-cultural and spiritual domains. Nurses felt supported when care technicians fit with the caring-healing-honoring approach to integral care and functioned with synchronicity to the patient/ family and nurses' needs. The nurses felt they had

good relationships with doctors and other care providers, and their manager, were respected by them, and saw these relationships as supportive to their work flow. This finding is consistent with Brewer's (2006) findings that work flow is impacted by the quality of team member relationships.

Nurses in this study felt empowered and that they made a difference in their patients and families lives. This was achieved by providing the patient and family with the care they wanted, and by helping them to make care decisions that resonated with their personal, social, economic and cultural preferences. Jacobs et al. (2005) examined nurses' perception of their work experience using a critical emancipatory-feminist methodology and a dialectic process of reflection and action and found that nurses experienced powerlessness, oppression, struggle and devaluation in their practice environments. In contrast, the nurses in this study felt empowered and discussed creating a caring-healing environment by establishing positive relationships with their patients and family members, respecting the patient's room as their personal space, including entering, being present, and exiting rooms in a manner that promotes privacy, dignity and respect for patient and family preferences.

They used the C.A.R.E. channel which has meditative music, nature scenes and guided imagery with vocal scripts to promote a calm, restful and peaceful environment in addition to giving pain, sleep and anxiety medications. Spirituality was important and two of the nurses discussed their use of prayer both for themselves and with patients who asked for it and had religious artifacts in their rooms. Beyond what the nurses did, they all embodied a felt sense of caring for their patients, and as Quinn (1992) states "they are the environment." There is no separation from the energy of caring and healing that one has for another; it permeates internal

and external environments through beliefs and intentions that are communicated by one's comportment and self-agency.

According to Frisch (2001), Selanders (2010), Dossey (2010) and Dossey and Keegan, (2009) complementary therapies are historically situated within nursing practice and found in Nightingale's work, which refers to the use of music, prayer and creating a healing environment for the patients' wellbeing. In regards to using CAM in nursing practice, nurses in this study reported that they are not educated to these modalities in their curricula and discussed interest in learning how these modalities can be further used in patient care. They request CAM and spiritual care consults for patients who express interest in these services. Barriers to using CAM in practice are lack of education, time and tasks. The patient care technicians or nurses' aides complete much of the direct physical care with patients; while the registered nurse completes assessments, medications, treatments, patient education and health counseling, participates in team meetings, documents and follows through with provider orders and diagnostics; thereby spending less direct care time with patients than less educated support staff. This was discussed in Drenkard's study (2008) that advises a redistribution of work processes to create more time for nurses to spend with their patients.

Magnet[®], Quality of Care and the Voice of Nursing

According to Aiken (2008), inadequate staffing and lack of educational support are the most cited reasons for low quality of care in the hospital. Nurses in this study felt their staffing was adequate and that they were supported by the structure of the unit where 1) a senior resource nurse floats and helps the staff; and 2) a collaborative and supportive team approach exists. They also reported a high quality of care and felt their nurse manager and other healthcare providers were open and accessible to hear and address their concerns. The nurses in the study identified

the need for continuing education regarding integral-holistic nursing, theory guided practice and their professional practice model. Nurses in the study believed they had a voice in shared decision making structures on the unit and direct care levels, but did not unanimously feel they had a voice at the organizational level. They were optimistic that they could voice concerns and ideas to their manager and had faith that she would carry their voice to the organizational level. They all felt comfortable voicing their concerns and desire to meet their patient's integral health needs to doctors, case managers, pastoral care and other team members.

The Magnet[®] culture fosters structural empowerment and the professional practice model is designed to inform nursing qua nursing (McClure & Hinshaw, 2002; Kramer Drenkard, 2008); but Armstrong and Laschinger (2006) found Magnet[®] structure alone is not enough to empower nurses. The culture of the unit and organizational system set the tone for nurse empowerment. Nurses in this study felt empowered to advocate for themselves and their patients. According to Kilpatrick (2008) praxis permeates practice and influences the structuring of relationships with colleagues, patients and families in the work environment. Facilitators to nursing praxis in this study included making time for reflection on practice, ideas, thoughts and actions; and dialoging with nurse educators and leaders in a collaborative and participatory manner. The nurses in the study confirmed this finding, and: 1) expressed the importance of their role in facilitating health and healing; 2) discovered they needed to incorporate self-care routines to care for themselves; and 3) began to investigate ways to further enhance human caring and integral health with co-workers.

Cultural, Personal and Professional Empowerment

Empowered caring (Falk Rafael, 2001) requires linking or partnering (i.e., nurse with nurse, nurse with patient, nurse with manager, nurse with doctor) to achieve optimal patient and

professional outcomes. The notion of linking was further explored by Persky et al. (2008) who used nurse patient dyads to investigate outcomes of Human Caring. Nurses in each of these studies, and in the current study, continue to be concerned with the many demands placed on their time. Nurses in this study admitted they do not take the time to reflect upon their practice and celebrate their positive outcomes. They valued the time spent in relationship with their patients and families, and felt they made a difference in their patients and families lives. The importance of relationships to caring was discussed by Davidson, Ray and Turkel (2011) who advise the patient-nurse relationship is the vehicle for culturally congruent caring and healing to occur. Nurses in this study confirmed this finding and focused on establishing and maintaining caring-healing relationships that fostered biogenesis (Halldorsdottir, 1997, 2007) and salutogenesis (Scharmer, 2007).

Integral-holistic nursing empowers nurses by facilitating autonomy and control over practice. It gives nursing the language and voice to say what nursing is and does; nursing qua nursing. Kramer et al. (2008) demonstrated that control over nursing practice (CNP) is linked to positive patient outcomes. Nurses in the study told stories that described positive patient outcomes related to helping patients get their integral health needs and care decisions met to their satisfaction. At times the patient's needs and wants were at odds to what medical providers wanted, and the nurses advocated and negotiated care with providers to ultimately meet the patient's wishes. Overall nurses in this study felt they had control over their nursing practice and that structures and processes supported them.

Nursing Education and Leadership Opportunities

Nurses in this study acknowledged a gap in education to nursing meta-language and did not realize they were giving theory guided care until they participated in emancipatory praxis

research with the nurse researcher who reflexively shared theoretical knowledge with participants. This supports Hines' (n.d.) and Lincoln's (2009) findings that advanced practice nurse educators and leaders translate theoretical language and care for staff nurses. The value of advanced practice nurses being available to provide continuing education to staff nurses is supported by this work. Staff nurses reported that they do not take the time to think about the basis of why they did what they did and how their actions supported integral health, healing and human caring. They just did what comes natural and upheld their ethical and moral deontology to do the best they could to help others. In the participatory action study by Persky et al. (2008), a professional practice model called Relationship Based Care in an ANCC Magnet designated hospital, which was based on Watson's Theory of Human Caring was examined. Persky et al. found exemplar caring nurses were sensitive to relationship stress and were the most experienced. This finding was in contrast to the current study; where the participants felt they were able to negotiate conflict with minimal relationship stress, and were of varied experience levels. Similarity between Persky et al.'s findings and the findings of this study are the nurses in both studies identified the importance of continuity of care and expressed their desire to know and view their patients and families as a whole.

Explicitly educating nurses to the language and behaviors of Integral Human caring begins with academia and continues in practice settings. Clark (2005) advises the process of nurse socialization into the healthcare milieu is an educational process of cultural transformation that begins in nursing school. In essence, we begin to teach nurses what nursing is and can be in nursing school and continue to teach and reinforce it in practice settings. Nurses are socialized by nurse educators and leaders and each other (Clark). Nurses in the study were of varying ethnic backgrounds, and all were educated in the United States except one. The nurse from India was

the only one who reported having education to holistic nursing in her nurses training program. If we are to further our profession, Kagan et al. (2009) advise nurses to “act out of a forthright attunement to holistic, humanistic and emancipatory values” (p. 76). But first we must teach these values, behaviors and skills to nurse educators and leaders, and to staff nurses and support staff. Nurses in this study expressed enactment of values based care in their relationships with patients, families and other team members as well as the desire to learn and do more in this regard.

Consideration for revising nursing curricula to teach from an integral-unitary theoretical framework is suggested from this work as a means to emancipate nurses and empower them at all levels with the language, cognitive and psycho-motor skills to fully embody an extant theory guided practice that includes complementary health modalities. The nurses in the study reported that they lacked education regarding their Magnet[®] program’s theory guided professional practice model, which is based on Watson’s Theory of Human Caring. Saving nursing theory for higher level academic education, and then only giving a cursory overview may be a disservice to the profession and those we serve.

The National League of Nursing’s (NLN) Educational Competency Model (ECM) (2010) provides a comprehensive scope for educating nurses at all levels that includes core values, integrating concepts and nursing program outcome goals. The core values in this model are consistent with the nurses’ values in the study, which are consistent with meta-theoretical concepts. The value of the ECM is that it provides a unifying framework across the continuum in nursing education from vocational nursing to doctoral nursing. Evolving and blending the NLN ECM (2010) with concepts from the Theory of Cultural Transformation (Eisler, 2010), the Theory of Integral Nursing (Dossey, 2008), the Theory of Human Caring (Watson, 2012) and

Emancipatory Praxis (Chinn & Kramer, 2008) may provide a theoretical basis for developing emancipatory academic and continuing education curricula.

Watson (2012) and Dossey (2008) advise we are in a state of multi-paradigmatic pluralism where integral nurses must use all ways of knowing and unknowing to impact internal, external and global health and health advocacy. If we develop and utilize a unified theoretical conceptual model to guide curriculum development in academic and continuing education milieus, then we may help nurses to better understand and communicate the complexities and value of nursing. This notion of the need for a unifying meta-theoretical foundation and language was iterated by Jarrin's work (2011, 2012); and validated by nurses in the study who felt they needed more education to fully understand and articulate nursing qua nursing.

Evolving a Unified Theoretical Framework for Nursing

The findings of this study supported Jarrin's (2012) work on developing a unified theory for nursing in which one finds philosophical and ontological elements of multiple theories of nursing from the Unitary Transformative world view. Jarrin states,

Nursing is situated caring, shaped by internal and external environments. These environments include: The individual nurse's state of mind, intention, and personal nursing philosophy, their scope, role, level of skill, training, and experience, societal and professional norms, values, and worldview, and social, political, and economic systems embedded in education and practice environments (p. 14).

To further develop a unified theory of nursing, nurses might be taught the philosophical basis and metaparadigm constructs of nursing's art and science early in their curricula and in continuing education forums where:

- 1) Human (nurse) is defined as a pan-dimensional being with free thought, will, action and the ability to learn, imagine, create, communicate and change.

- 2) Humans (nurses) are influenced by and influence environments (internal, external, global, and cosmic) without separation, a change ripples to affect and effect in multiple and omnipotent directions.
- 3) Humans (nurses) perceive, utilize and demonstrate multiple ways of knowing, doing and being in her/ his life-world (personal, social, political, aesthetic, professional, moral-ethical, intuitive, emancipatory, and spiritual).
- 4) Nursing (practice, research, education and leadership) is dialogical (communicative) and relational (social) in nature.
- 5) Nursing (practice, research, education and leadership) is conducted using communication (tactile, auditory, visual, verbal, non-verbal, written, energetic) and social skills (interpersonal connecting, sharing, coaching, guiding, role modeling, enlightening, and authentic-presencing) in the ever evolving teaching-learning experiential situation (socio-cultural, context, and caring-healing-emancipating environments).

Watson's (2012) focus on humanitarianism and the ethical-moral deontology to hold self and others in the highest esteem resonates with the emancipatory praxis of integral nursing, where nurses learn to hold themselves and their work in the highest esteem. This is achieved by shedding light for nurses on what they do and how they do it through the critical narrative inquiry process with the researcher (Kim, 2010). The nurses in the reflective and emancipatory phase of the study expressed increased awareness of their practice and identified practice changes they wanted to make based on the transformative learning experience of participating in the study. They also wanted to bring this work to their nurse colleagues, and share what they learned, with a desire to create change towards expansion of theory guided practice and Human

Caring on the unit. One participant said, “I want to share this because this is how I think they want to practice, but don’t know that they can or do.”

Nurses in the study reported a sense of renewal and reverence for the work they do after participating in the critical narrative inquiry process. This study’s findings resonate with Gregg and Magilvy’s (2004) work that found nurses demonstrated caring values and believed that the work of nursing brings meaning to one’s life. Critical narrative inquiry and education to theory guided practice helps nurses to see what nursing is and can be, nursing qua nursing. It helped them to find the language to articulate nursing’s values, beliefs, and power so that they might transcend historical and culturally prescribed roles and mores to enter into new ways of thinking and being for the purposes of self-transcendence to higher levels of health and healing in the world.

Limitations of the Study

According to Polit and Beck (2004) limitations of a research study include 1) sample deficiencies; 2) design problems and 3) weaknesses in data collection. The following discussion will address the study limitations and how they were moderated. It will conclude with areas for future research.

Sample deficiencies: In this study sample deficiencies include a small, self-selected sample size. The nurses were from a single institution and the service line of Oncology. Oncology nurses are familiar with non-medication comfort measures and palliative care. They deal with life limiting illnesses and often help their patients make end of life choices. In addition, the study was conducted in a faith based organization, which may have enhanced the nurses’ awareness to spirituality, prayer and a holistic-integral approach to care. The study was conducted in an ANCC Magnet[®] re-designated facility where nursing excellence is fostered and

nurses are empowered as caring agents. This may have skewed results towards positive findings of empowerment. In addition, since the nurses self-selected, participants may have been nurses who felt strongly about the subject matter and were perhaps akin to the values and beliefs of the study. In essence, they may have volunteered their time to participate in the study more readily than other staff nurses.

Design problems: In relation to study design, the participatory qualitative design involves dialogue and education with the nurse researcher and participant in one on one private interviews, which fostered a mentoring relationship and a partnership towards meeting the study goals. It is possible that this led the nurse participants towards transformative changes that may not have occurred if the design was more phenomenological in nature. Efforts made to minimize this limitation included the nurse researcher paraphrasing and asking for further data to clarify the nurse participants' reports of experiences, beliefs and behaviors.

Data collection: In this study, potential weaknesses in data collection and analysis included that critical narrative inquiry aims to hear, capture and communicate the nurse participants' voice in her/his own words. A potential weakness may have been that the nurse researcher, did not fully capture the nurses' voice, and may have only heard the salient features as perceived by her. Efforts made to moderate this limitation included audio recording and transcribing by listening, writing, reading and proofing data repeatedly until the researcher was clear that the nurses' voice was heard and the data were from the nurse participants. In addition, each nursing unit and healthcare system has its own set of values and sociocultural attributes that influence outcomes; hence if this study is replicated in a similar setting, but in a different nursing unit and with different nurses, outcomes may vary.

Areas for Future Research

Implications for future research would be to replicate the study with a larger, randomized sample size, in non-faith based healthcare organizations within other Magnet[®] designated and non-Magnet[®] designated healthcare organizations and across multiple diverse service lines. Further work is suggested in relation to developing an extant emancipatory curriculum to provide continuing education to nurses grounded in the work of theory guided integral practice.

Academic curricula might be revised to more explicitly expose and teach theoretical elements inherent in nursing at basic nursing levels, and support staff might also be educated to these concepts, values and behaviors. Additional research to examine the outcomes of such curricula would subsequently be warranted. In addition it was found by this study that theory both informs and is informed by nursing practice-research. Kagan et al.'s (2009) call for further emancipatory praxis based, philosophically explicit research was addressed by this small study and further work is suggested to better understand the impact of theoretically guided education-practice.

Each nursing unit and healthcare system has its own set of values and sociocultural attributes that influence outcomes. Organizational cultures vary based on a multitude of factors. The impact of a nursing department's philosophy upon its professional practice model and nurse comportment warrants further research. Questions remain regarding the extent to which the organizational culture impacts the individual nurse's values, beliefs, comportment and self-agency. It is also not clear from this study the extent to which the ANCC Magnet culture of the organization influenced the individual nurse; although it was evident that the participants in this study felt empowered as caring agents and supported by their nurse manager.

This study found the nurses to be transformative agents, assisting her/his patients in adaptive bio-psycho-sociocultural change towards optimized Integral health and transition to a peaceful death in the manner and place that was meaningful to the individual. The nature of this relationship and the qualities of the nurse warrants further investigation. Emancipation is influenced multiple patterns of knowing and sociopolitical factors. Questions remain regarding the extent to which emancipatory praxis facilitates the transformative agency of the nurse to impact health outcomes in a multitude of healthcare venues and roles beyond those of this study. Further research may evaluate transformative agency in various in and outpatient registered nurse and nurse practitioner roles. This finding of the nurse as transformative agent may help nurses to further understand and communicate the unique value and role of nursing as a profession worthy of garnering further sociopolitical and economic status. It would be interesting and valuable to conduct qualitative and quantitative studies that evaluate care and cost outcomes of the transformative agency role of the nurse.

Summary and Conclusion

This critical narrative study revealed that eight nurses in one Magnet[®] re-designated hospital's Oncology unit embodied Human Caring and Integral Nursing theoretical concepts to inform their professional practice, even though they reported limited education to the theories and the professional practice model of the hospital. The theoretical concepts of Human Caring are inherent in the practice of nursing and in the comportment of nurses who self-selected to participate in this study. Human caring is also infused throughout the culture of nursing care at this single ANCC Magnet re-designated hospital on this single nursing unit; which impacted social mores and values. Elements of the theories that manifested in dialogue with the nurses were: advocating, educating, counseling, creating a caring-healing environment by honoring the

patient and family's space and wishes, approaching patients and families non-judgmentally with an open mind and loving kindness, using complementary modalities such as prayer, intention, authentic presence, music, imagery, touch, and obtaining complementary therapy and spiritual care consults for patients.

The nurses in the study identified facilitators to their practice as being the support of their manager, colleagues and team members, optimal staffing patterns, resource nurses and competent, self-motivated care technicians and support staff. They felt they had a voice and could make changes in their practice as they saw fit at the local unit level. They appreciated the support of their manager and the hospital for the benefit of advanced education, tuition reimbursement, flexible scheduling, and to be able to participate in and use the most current nursing research in their practice.

The nurses identified a need for continuing education and advanced practice nursing support for education on the unit. They reported a strong mentoring culture and felt they empowered each other to do the right thing, and advocated for patients' and nurses' rights in the healthcare environment. The nurses identified a desire to bring their insights and education regarding theory guided practice to their nursing colleagues on the unit. They discussed developing a formalized venue for sharing knowledge, skill and attitudes about integral health and caring-healing language, strategies and values with the other nurses on the unit.

This study identified a gap in education and advanced practice support of staff nurse practice with the opportunity for nursing education and leadership to develop novel curricula in both academic and continuing education venues to help nurses see what nursing is and can be. This notion aligns with the Robert Wood Johnson Foundation/ Institute of Medicine's Report on

the Future of Nursing (National Research Council, 2011) that advises nurses to practice within the full scope of their professional abilities for the optimal health of society.

Findings from this critical narrative inquiry study confirm that the Magnet[®] hospital in this study supports: 1) staff nurses to pursue advanced education and participate in nursing research; and 2) nurses' control over their practice through structural empowerment processes. This study adds to the body of nursing knowledge on theory guided practice and nursing qua nursing regarding: 1) the emancipation of nurses involves their ability to sense and see patterns that affect their freedom, voice and creativity as they promote and advocate for integral health; 2) Integral Nursing Theory (Dossey, 2008) illuminates nursing qua nursing, which informs and is informed by nursing praxis; 3) Human Caring (Watson, 1985) is expressed through nurse comportment and self-agency in the nursing care relationship, context and situation; and is impacted by sociocultural influences upon the nurse, patient and practice environment; and 4) the Peace and Power (Chinn, 2008) partnership approach to praxis facilitates the transformative learning needs of nurses. Nursing education and leadership opportunities exist for further research in this area of study and the development of novel curricula as the profession seeks to enhance and expand the role and status of nurses.

Emancipation is the freedom to imagine new and improved ideas and ways of being in the world by illuminating one's thoughts, beliefs and actions as one authentically becomes in relation to one's internal and external environments. The emancipatory praxis of Integral Nursing helps nurses to see, articulate, expand and evolve nursing qua nursing.

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Appendices

Appendix A: Sparber's Analysis of State Boards of Nursing Position on Complementary Therapies in Nursing

Results of Boards of Nursing (BON) That Permit Complementary Therapy in Nursing Practice

(N= 53)

Category	State
Scope of Care Described	
Permit Practice	Arizona
47% of BONs	Arkansas
N=25	California
	Connecticut
	Illinois
	Iowa
	Kansas
	Kentucky
	Louisiana
	Maine
	Maryland
	Massachusetts
	Mississippi
	Missouri
	New Hampshire
	New York

	Nevada
	North Carolina
	North Dakota
	Ohio
	Oregon
	Pennsylvania
	South Dakota
	Texas
	Vermont
	West Virginia

Appendix B: Sparber's Compilation of Complimentary Therapies in Nursing

Compilation of Complementary Therapies

Categories*	Practices
Mind/body interventions	Art Biofeedback Focused breathing Holistic Nursing Humor Meditation Music Visual imagery Yoga
Alternative medical system	Acupressure Oriental massage Biological-based therapies Diet and nutrition (not herbs)
Manipulative/body-based systems	Aromotherapy Cranial-sacral Deep muscle massage Effleurage Esalen

	Feldenkreis Friction Heller work Infant massage Lomilorri Lymphatic drainage Myotherapy/Myofascial Neuromuscular Petrissage Reflexology Shiatsu Structural integration Swedish massage
Energy therapies	Healing Touch Therapeutic Touch Reiki
*NCCAM categories	

Sparber, A. (2001). State Boards of Nursing and scope of practice of Registered Nurses performing complementary therapies. *The Online Journal of Issues in Nursing*, 6(3).

**Appendix C: Office of the Professions New York State Education Department's Nursing
Guide to Practice: New York State Board of Nursing Statement on Independent Role of the
Registered Nurse**

Registered Nurses may function independently in providing nursing care in such areas as:

• Case finding, including but not limited to,

- Identification of epidemiological trends
- Client abuse assessment
- Early identification of emergent complications

• Health Teaching, including but not limited to,

- Patient teaching re: signs and symptoms of medication side effects
- Patient teaching regarding disease process (heart disease, cancer) and management in relation to life factors such as culture and ethnicity
- Health care promotion, such as disease prevention, accident prevention, and teaching normal child growth and development

• Health Counseling, including but not limited to,

- Mental health counseling
- Addiction counseling
- Health counseling related to management of chronic diseases such as Alzheimer's, Parkinson's, Bi-Polar and Diabetes

• Care Restorative of Life and Well Being, including but not limited to:

- Rehabilitation services such as bowel/bladder training, ostomy/wound care
- Triage and continuous assessment for early identification of signs and symptoms of postoperative complications with timely intervention

- Ongoing surveillance and nursing intervention to rescue chronically ill persons from development of negative effects and secondary results of treatment
- Care Supportive of Life and Well Being, including but not limited to:
 - Hospice and palliative care
 - Chronic pain management through non-pharmacological nursing measures such as ergodynamic techniques, relaxation, imagery, therapeutic touch, and rational-emotive therapy (RET)
 - Public health care including elder care, well-baby care, school and industrial nursing.

Office of the Professions New York State Education Department (2009). *Nursing guide to practice*. Albany, NY: The University of the State of New York.

Appendix D: Philosophical Assumptions of Dossey's Theory of Integral Nursing**Philosophical Assumptions of the Theory of Integral Nursing:**

1. An integral understanding recognizes the individual as an energy field connected to the energy fields of others and the wholeness of humanity; the world is open, dynamic, interdependent, fluid, and continuously interacting with changing variables that can lead to greater complexity and order.
2. An integral worldview is a comprehensive way to organize multiple phenomena of human experience from 4 perspectives of reality:
 - (1) individual interior (subjective, personal);
 - (2) individual exterior (objective, behavioral);
 - (3) collective interior (intersubjective, cultural); and
 - (4) collective exterior (interobjective, systems or structures).
3. Healing is a process inherent in all living things; it may occur with curing of symptoms, but it is not synonymous with curing.
4. Integral health is experienced by a person as wholeness with development toward personal growth and expanding states of consciousness to deeper levels of personal and collective understanding of one's physical, mental, emotional, social, and spiritual dimensions.
5. Integral nursing is founded on an integral worldview using integral language and knowledge that integrates integral life practices and skills each day.
6. Integral nursing is broadly defined to include knowledge development and all ways of knowing.
7. An integral nurse is an instrument in the healing process and facilitates healing through her or his knowing, doing, and being.
8. Integral nursing is applicable in practice, education, research, and healthcare policy.

Dossey, B.M. (2008). Theory of integral nursing. *Advances in Nursing Science*, 31(1), E52-E73.

Appendix E: Watson's Ten Caritas Processes

Dr. Jean Watson's Human Caring Theory: Ten Caritas Processes

1. Embrace altruistic values and Practice loving kindness with self and others.
2. Instill faith and hope and honor others.
3. Be sensitive to self and others by nurturing individual beliefs and practices.
4. Develop helping – trusting- caring relationships.
5. Promote and accept positive and negative feelings as you authentically listen to another's story.
6. Use creative scientific problem-solving methods for caring decision making.
7. Share teaching and learning that addresses the individual needs and comprehension styles.
8. Create a healing environment for the physical and spiritual self which respects human dignity.
9. Assist with basic physical, emotional, and spiritual human needs.
10. Open to mystery and allow miracles to enter.

Inova Health & Watson, J. (2007). *Caritas Factors refined*. Retrieved from

http://watsoncaringscience.org/images/features/library/Watson10_caritas%20factors%20colored%20list.pdf

Appendix F: Integral Nursing Questionnaire

Integral Nursing Questionnaire

Name/title _____

Date _____

email: _____ Cell phone _____

Item	Yes	No	Circle Best Answer	Describe- Comments
Undergraduate RN Education	Yes	No	Diploma ADN BSN	Year of entry into practice as RN: College graduated from:
Graduate RN Education	Yes	No	MSN Doctorate	Years attended: College graduated from:
Current Age	Yes	No	<20 years 20-30 years 31-40 years 41-50 years 51-60 years >61 years	

Ethnicity	Yes	No	African-American Asian Caucasian Hispanic Island Other	
Clinical Experience	Yes	No	1-5 years 6-10 years 11-15 years 16-20 years 21-25 years 26-30 years 31-35 years 36-40 years >41years	Type of Clinical Experience/ Specialty: Years in specialty:
Years on current clinical unit	Yes	No	<1 1-5 years 6-10 years 11-15 years 16-20 years 21-25 years 26-30 years 31-35 years	Type of Unit:

			36-40 years >41years	
Education in Nursing Theory	Yes	No	In Nursing School In Hospital Conference Other	Year: Theory/Theorist(s): Describe how you use theory in your practice:
Education in Integral-Holistic Nursing	Yes	No	Sponsored by the American Holistic Nurses Association Other Nursing Continuing Education	Year(s)/Topic(s):

<p>Do you use any of these modalities in your nursing care? (If yes please circle the ones you use)</p>	Yes	No	<p>Acupressure Acupuncture Alexander Technique Aromatherapy Authentic Patterning Authentic Presencing Guided Imagery Healing Environment Healing Touch Health Counseling Massage Music Reiki Relaxation Stress Management Therapeutic Touch</p>	<p>Please list any that you use for your own self-care:</p>
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Appendix G: Critical Narrative Inquiry: Three Phases

The study was introduced and presented by the researcher to the Oncology Unit nursing team and to the Nursing Research Council at the hospital. Participants who self-selected were contacted by the researcher and enrolled in the study if they met inclusion criteria. The researcher scheduled meetings with participants, provided informed consent and administered the demographic questionnaire. Participants met and dialogued with the researcher in three phases. Each phase was conducted in a private office or conference room setting at the hospital, and sessions were audiotaped using an iPhone digital recorder. The audiotapes were transcribed by the researcher using the NVivo 10 qualitative software program. Study data was validated by the participants in each phase and upon conclusion of the study. Each participant was given access to her/his secure data only by electronic mail. A summary of the study findings will be presented to the Oncology Unit nursing team and Nursing Research council upon defense of the research study.

Phase One: Descriptive

The nurse was asked to tell a story of a recent practice event, case or situation when she/he used the Theory of Human Caring/ Caritas Processes to guide her/his practice. Focus included the nurses' thoughts, feelings, actions and how she/he (the nurse telling the story) was impacted by using caring-healing modalities and independent therapeutic nursing interventions that enhanced her/his patients bio-psycho-socio-spiritual health. The nurses were also asked how their own health was affected by using Caritas processes when providing care to her/his patients, and how they created a caring-healing environment in the acute care hospital setting.

Watson's Ten Caritas processes (Inova/ Watson, 2007) were reviewed with the nurses prior to her/his telling her/his story, so as to refresh the nurses' memory:

- 1) Embrace altruistic values and practice loving kindness with self and others.
- 2) Instill faith and hope and honor others.
- 3) Be sensitive to self and others by nurturing individual beliefs and practices.
- 4) Develop helping–trusting-caring relationships.
- 5) Promote and accept positive and negative feelings as you authentically listen to another’s story.
- 6) Use creative scientific problem-solving methods for caring decision making.
- 7) Share teaching and learning that addresses the individual needs and comprehension styles.
- 8) Create a healing environment for the physical and spiritual self which respects human dignity.
- 9) Assist with basic physical, emotional, and spiritual human needs.
- 10) Open to mystery and allow miracles to enter. (Watson & Inova Health, 2007)

Phase Two: Reflective

The participant and researcher conducted a reflective analysis of the story exemplar by: reading, reflecting and dialoguing about the participant’s practice exemplar (story) in three parts;

- 1) Against the espoused Theory of Human Caring (Ten Caritas Processes)
- 2) On the case or situation described
- 3) On the nurses intentions in the practice exemplar (Kim, 2010, 2012).

The researcher analyzed the transcribed data and wrote narrative exemplars of the nurses theoretically based practice and of her/his manifestation and awareness of nursing qua nursing (nursing for the sake of and in the character role of nursing), and how her/ his comportment (thoughts, feelings and actions) and self- agency (embodied knowledge, voice, and power) was

reflected in the process. Reflective phase data resulted in a knowledge product of the practice processes, and applications of the nurse awareness of her/ his self-agency.

Phase Three: Critical/ Emancipatory

In the critical/ emancipatory phase, the researcher and participant read, reflected and dialogued focusing on a critique of reflective practice exemplar regarding conflicts, distortions and inconsistencies that manifested in the previous phase, thereby engaging in an emancipatory change process. The emancipatory change process results in a transformational learning experience for participants, as participants contemplated her/his ability to change social behavior and practice (Kim, 1999, 2007, 2010). The dialogue from this phase was transcribed into emancipatory exemplars by the researcher and validated by the nurse participants by electronic mail.

Appendix H: Operational Definitions

Assimilated Caring: A term coined by Falk-Rafael that denotes the nurse's acquiescence to dominator systems of power over her/him as directing her/his caring behaviors and practice.

Autonomy: To be fully functioning in an independently responsible role for one's actions.

Barriers: Those factors that impede, prevent, or make difficult the application of one's free will, autonomy, democracy, voice, power, and have control over one's life, environment and professional practice.

Caring: A central theme of nursing practice that describes the process of Caritas (loving kindness) (Watson, 2012) that places the patient in the best position for nature (Nightingale, 1895) and traditional and modern therapeutics to act upon her/him for the purposes of facilitating healing (Dossey, 2008). Caring may be associated with preventative, restorative, supportive and comforting health practices.

Caring-Healing Modalities: Biopsychosociospiritual therapeutic actions that promote healing and the integration of past-present-emerging future toward an evolved state of health, or towards a peaceful death.

Caring-Healing Ontology: An orientation to relationships of humans and nature to treat everyone and everything with loving kindness. It acknowledges the power of intention and consciousness as it affects the health of self, another and the universe.

Caritas: To hold self and others dear; to use loving kindness with self and others in all transactional and transpersonal encounters (Watson, 2012).

Complementary and Alternative Modalities: Natural therapeutics that are supportive, restorative and preventative to health and wellbeing such as Reiki, Healing Touch, Guided

Imagery, Music, Healing Environments, Relaxation and Stress Management, therapeutic massage, the Alexander technique (psychophysical education).

Complexity Theory: The study of complex systems and the interrelationships that exist in, around and between them.

Compartment: “Style, intents, and manner of acting and interacting, which includes gestures, posture and stance; thoughts and feelings that are fused with physical presence and action: includes one’s ways of being with patients and families, such as tone of voice, touch, accessibility, tact and staying open and curious in clinical situations” (Benner, Kyriakidis & Stannard, 2011, p. 555).

Consciousness Raising: The socio-political act of examining relationships and their impact on thought, feelings, behavior, power and control.

Constructive Conscious Control: A term coined by F.M. Alexander (1923) to denote the process of kinesthetic and intellectual awareness of pattern and one’s ability to inhibit action as means toward learning and developing new patterns of thought and action.

Control Over Nursing Practice: The nurses ability to enact an independent practice. Maybe influenced by levels of education, status, stereotype, gender, human agency, power and role.

Critical Narrative Inquiry: A term coined by Kim (1999, 2007, 2010) to describe the research method of description, reflection and emancipation. Designed to produce the knowledge product of emancipatory praxis; transformative learning of theory-practice link.

Critical pedagogy: Freedom from oppression through education and liberation.

Cultural Transformation Theory: A theory coined by Eisler (1987) to describe the process of evolving towards a gender holistic partnership based social system.

Dialogue: To engage in authentic I-Thou relationship (Buber, 1958) for the purposes of sharing and connecting with others, nature, and the universe. Sharing may involve presence, talking, deep listening, and any form of expression of one's ideas and the meanings she/he finds within and outside one's self. The free exchange of thought, ideas and information, for the purpose of transforming self and culture to facilitate the unfolding of meaning and the liberation of new ideas (Bohm, 1996).

Dominator Systems: A social structure that uses authority and power over people.

Democracy: Equality for all; shared decision making and rights to free speech and the pursuit of social justice, freedom and liberty.

Emancipatory Knowledge: Knowledge that is generated by nurses as they critique the status quo. An emancipatory critique asks five critical questions: 1) who benefits; 2) what are the barriers; 3) what are the facilitators; 4) how am I complicit in maintaining the status quo; and 5) what are the feelings, thoughts and actions in a situation that either free or enslave me? (Chinn & Kramer, 2008).

Emancipatory Praxis: The process of freedom, empowerment, growth, development and enlightenment that results from transformational learning and experience of reflection and dialogue, as one critically evaluates one's internal and external environments in relation to embodying and enacting a theory guided practice-education-inquiry.

Empowered Caring: A term coined by Falk-Rafael (1995, 2001) that denotes the nurse's experience of nursing qua nursing as expressed by her/his ability to provide care without restrictions to freedom, democracy, voice and power.

Empowerment: The development of strength, confidence, power, knowledge, language and voice through increasing human agency and capacities of self and group.

External Environment: Consists of one's socio-cultural, ideological, historical, relational, and structures outside of oneself.

Facilitators: Those factors that enhance one's ability to fully embody and apply free will, autonomy, democracy, voice, power, control over one's life, environment and professional practice.

Formal Power: Structural, assigned and authoritative power

Habit of Mind/ Thought: Patterned beliefs and thoughts that inform and precede action and interpretation of experience.

Healing: The emergence of integration and a balanced relationship of environments and the body-mind-spirit. The generation of a sense of peace, contentment and wholeness with one's life in the present moment. Creating harmony in internal and external environments for the purposes of facilitating health or illness to take its natural course with peaceful awareness and acceptance of the highest good.

Healing Environment: An energetic and physical space that is welcoming, comforting, and collegial, and facilitates a sense of peace, health, wellbeing, rest and contentment.

Hegemony: The set of beliefs that maintain the status quo.

Holistic Nursing: Nursing that addresses the bio-psycho-socio-spiritual nature of human health and life within the nursing metaparadigm. It recognizes the science of psychoneuroimmunology and combines culturally competent, caring-healing, complementary and alternative health practices with biotechnical care to facilitate health for persons and environments.. Holistic nursing is the historical basis of all nursing practice, and also a specialty practice according to the ANA and AHNA (Dossey & Keegan, 2009).

Human Agency: The capacity for one to act within one's social structure. Involves making informed choices within one's life-world.

Human Caring Science: Inquiry into the personal and professional outcomes of Caritas processes, consciousness, curriculum and competencies as informed by the Theory of Human Caring (Watson, 2012).

Ideology: A set of beliefs and values held by people, group, community and society. contexts which includes the energy that is associated with these factors.

Informal Power: The ability to influence another through relationship.

Inhibition: The intentional ability to pause before taking action (Alexander, 1923)

Integrality: "Reflects the oneness and unity or wholeness of humans and their environment.

In nursing practice, integrality involves the realization that the observer is integral to what he or she is observing" (Jarrin, 2012, p. 14).

Integral Health: A philosophy and view of the world and its effects on one's physical, mental, emotional, social, political, spiritual and sexual health through the lens of All quadrants and All levels of micro to macro salutogenesis (Wilber, 2000; Scharmer, 2008). A continual process of reevaluating one's world view, perspective, understanding, beliefs and behaviors that impact one's choices in life and death (Dossey, 2009).

Integral Nursing: A multi-metaparadigmatic and multi-meta-theoretical process of and life world view that includes and transcends holistic nursing. Integral nursing embraces multi-pluralism and partnership. It allows the nurse to know, see, and do nursing from the broadest context of person, health, healing, internal and external environments (Fiandt et al., 2003; Dossey, 2008; Jarrin, 2011, 2012)

Internal Environment: Consists of one's thoughts, feelings and the energy associated with these, as well as one's biochemical and fluid constituency.

Magnet[®] Designation: The gold standard of nursing excellence designated by the ANCC to recognize healthcare systems that support and facilitate professional nursing. Associated with higher levels of nurse education, shared governance, theory guided professional practice model, lower mortality and infection rates and higher patient and nurse satisfaction scores as compared to non-Magnet[®] healthcare systems (McClure & Hinshaw, 2002)

Metalanguage: The vocabulary to describe and analyze integral nursing. Jarrin (2012) states, "Expert nursing involves complex pattern recognition of the integrality (unity) between humanbeings and their environment while considering multiple perspectives: the individual-objective view of organism and structured development, the inter-subjective view of culture or worldview, and the inter-objective realm of social systems and structures" (p. 17).

Metaparadigm: Describes nursing's central constructs of humanbeing, health, environments, and the art and science of nursing.

Metatheory: A theory designed to analyze other theories and their constructs.

Method: A technique or series of actions designed to achieve an outcome.

Narrative Epistemology: Knowledge generated through narration or story.

Nursing qua Nursing: Nursing for the sake of and in the character and role of nursing.

Oppression: Power over another to press down upon and cause burden, adverse experience or condition to another or from one group over another so as to suppress freedom, liberty, happiness, power and voice.

Partnership Systems: Power with, shared experience of flexible and flat social systems that are class, race, religion and gender holistic (Eisler, 1987).

Patterns of Knowing and Not-Knowing or Unknowing in Nursing: Terms coined by Carper (1978), White (1995), Munhall (1993) and Chinn and Kramer (2008) as ways in which nurses understand, interpret and apply knowledge which include: Personal: Inner experience, self-awareness, therapeutic use of self, one's story, normative views of life-world; Ethics: Moral and ethical comportment, principles and codes of behavior; Empirics: Sensory experience, the creation and use of theoretical and scientific knowledge; Emancipatory: Sociopolitical use of praxis to evaluate and transform social structures, facilitate empowerment and social change, power with people; Aesthetic: Deep appreciation of meaning, symbolic interpretation, know what to do, how to do it in the moment, intuition, use of creative resources to express, understand and transform one's experience; story, poetry, art, dance, film, music...; Not knowing/ Unknowing: Open to the subjective experience and perceptions of another, setting aside one's assumptions, personal openness, existential availability, receptivity to know that which is not yet known.

Peace and Power: A term developed and coined by Chinn that describes a participatory, partnership, feminist and gender holistic approach to community building through shared dialogue and power (Chinn, 2008).

Pedagogy: The art and science of teaching.

Philosophy: Inquiry into the traits of reality and principle of values.

Power: The knowledge, capacity and ability to act in a free, ethical and responsible manner with self, others and the environment.

Praxis: Values made visible (Chinn, 2008), thoughtful, theoretically guided reflection and action, power with others, empowerment from using all patterns of knowing, doing & being.

Presencing: Seeing from one's deepest source, to be fully present in the moment and fully sensing at the same time, to act from one's best self and to be fully awake. "Learning from the future as it emerges through presencing... suspending, redirecting, letting go, letting come, envisioning, enacting, and embodying" (Scharmer, 2008, p. 467).

Qua: a Latin term, first used in 1647 for: as with, being with, and in the character or role of (Merriam Webster, 2011).

Reflection: To carefully consider, critique and evaluate one's experience, thoughts, feelings, actions and ideas. Reflection in action is to consider all possible ideas, thoughts, feelings and actions while engaging in an act.

Salutogenesis: A partnership approach to healthcare delivery where the provider of care shares power with the patient and facilitates optimal health by supporting wellbeing (salut =health, genesis= development (in Greek) (Scharmer, 2008; Eisler, 2010).

Self-Agency: Embodied power through one's active compartment, knowledge and voice.

Situated Caring: A term described by Jarrin (2011, 2012) that describes the essence of nursing in relationship with self and patient, affected by internal and external environments, impacting health.

Social Justice: To uphold and create a community of unity, solidarity and respect for differences and diversity as a sense of wonder, responsibility and value the social richness of character and morality (Fowler, 2008).

Structural Empowerment: Organizational, cultural and social system processes that foster participation, education, power, shared decision making, voice and control over one's practice.

Tacit Knowledge: Subjective knowledge embedded in one's experience and psyche; influenced by socio-cultural beliefs and values. Impacted by socialization, mental models or schema has

cognitive and technical aspects (know what and know how) (Benner, 1984; Benner, Kyriakidis & Stannard, 2011).

Theory: Creative and rigorous structuring of ideas and concepts to view phenomenon.

Transformative Learning: A term coined by Mezirow (2000) to denote the change that an adult learner undergoes when she/ he reevaluates her/his knowledge and experience; and questions or contests preconceived ideas, beliefs, thoughts, schema and hegemony. An emancipatory process of change and re-creation of self.

Voice: To speak, articulate and use language and behavior to fully express one's self, one's value and one's potential.

