RESEARCH GUIDELINES FOR ASSESSING THE IMPACT OF THE HEALING RELATIONSHIP IN CLINICAL NURSING

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The term healing relationship has been defined by the Samueli Institute for Information Biology (SIIB) consensus group as "the quality and characteristics of interactions between healer and healee that facilitate healing. Characteristics of this interaction involve empathy, caring, love, warmth, trust, confidence, credibility, honesty, expectation, courtesy, respect, and communication."[1] Combining elements of this definition with the SIIB definition of healing gives a fuller sense of the concept: "Those physical, mental, social, and spiritual processes of recovery, repair, renewal, and transformation that increase wholeness.... Healing is an emergent process of the whole system, and may or may not involve curing."[1]

If the relationship between practitioner and client, between healer and healee, is in fact a variable in healing, then whatever is healing in that relationship warrants rigorous discernment. Furthermore, because the role of healer is not specific to gender or discipline, guidelines for inquiry into healing relationships must transcend disciplinary boundaries. Nevertheless, each discipline brings its own focus and way of conceptualizing this relationship and thus contributes a unique perspective. The American Nurses Association has long defined nursing as the assessment, diagnosis and treatment of human responses to actual and potential health problems, combining the art of caring and the science of healthcare.[2] Nursing is grounded in the philosophy and science of human caring ,[3] with its purpose being to "put the patient in the best condition for nature to act upon him."[4(p133)]

The purpose of this paper is to explore the healing relationship through the disciplinary lens of nursing and to propose guidelines for research methodologies that might help to elucidate both the process and outcomes of healing relationships in clinical nursing practice. These guidelines might be applied to research on the impact of healing relationships between clients and other health professionals as well. The checklist at the end of this paper summarizes the quality guidelines.

RATIONALE FOR STUDYING THE HEALING RELATIONSHIP IN CLINICAL NURSING PRACTICE

Across disciplines there exists both theoretical and empirical support for the claim that the relationship between clinicians and their patients is an important component of practice. What is not uniform across disciplines is the relative emphasis on this relationship as being integral to both the processes and outcomes of practice. In nursing, a focus on the whole person and the relationship between nurse and patient are both central and primary. There are at least 6 cogent reasons for studying the healing relationship in nursing:

1. If the healing relationship is a factor in the outcomes of both conventional and complementary therapies, then nurses, as the largest group of healthcare professionals, are in key positions to add that element where it is missing and sustain it where it exists.
2. Nursing as a profession is being challenged by a profound shortage that has dramatic implications for the health of the healthcare system.[5] One reason for the shortage is that nursing work forces have been downsized in uninformed attempts to save money. Perhaps it was unfortunate ignorance of the role of the nurse-patient relationship in healing that helped to create this problem. Research in this area might serve to ameliorate this ignorance.

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3. Theoretical literature in nursing asserts an association between caring/healing relationships and healing outcomes. It is important to study these assertions through well-designed scientific inquiry employing multiple methodologies.
4. Outcomes-focused studies can provide a much-needed rationale for improving care practices.
5. The measurement of healing relationships is essential to document their occurrence, provide empirical evidence of their outcomes, and ultimately enable the development of patient-oriented and family-oriented "report cards" about the quality of relationship-centered care as delivered through units or institutions.
6. Heuristically, outcomes studies can lead to the support, extension, or rejection of existing theories of the healing relationship and can stimulate further inquiry.

QUESTIONS FOR RESEARCH

The first step in conducting research on any topic is the identification of salient research questions. The broad, overview question under consideration here is what is the impact of the healing relationship in clinical nursing practice? Embedded in this question are dozens of other questions, many of which will require attention before the larger question can actually be answered. The following 20 are some of those questions, which do not exhaust the possible inquiries.

1. How can we assess "processes of recovery, repair, renewal and transformation that increase wholeness"?
2. If "healing is an emergent process of the whole system, and may or may not involve curing,"[1] how do we begin to assess the impact of the healing relationship on the whole system, including the clinician who is a part of that system?
3. What are the indicators of healing, particularly healing that does not include curing, and what are the appropriate measurements of these indicators?
4. How can we assess wholeness? How do we know it when we see it?
5. What are the essential mechanisms through which healing relationships are enacted?
6. What constitutes a "healing relationship" in the experience of both nurses and patients?
7. What are the necessary and sufficient elements that must be present in an interaction between people to make it a healing relationship?
8. How do participants in a healing relationship characterize both the process and its outcomes?
9. Do both members of the dyad concur on the essential elements or mechanisms through which healing is experienced?
10. Are there measurable indices of the occurrence of healing relationships?
11. Is time a necessary factor in the development and existence of a healing relationship or can a healing relationship be constituted in one "caring moment"?[1]
12. Is face-to-face proximity required for a healing relationship?
13. Can we separate healing intentionality and energy from the healing relationship?
14. Must both members of a dyad perceive the relationship as healing for it to be labeled as such, and is this related to outcome?
15. Can there be a healing relationship with a patient with whom there is no verbal communication, ie, a comatose patient, or a person with advanced Alzheimer's disease?
16. Is it still a healing relationship if there is no observable outcome other than the participants' claim that it was a healing relationship?
17. Which standard health-related outcomes are most influenced by the healing relationship?
18. If there is an impact on healing related to the healing relationship, what is its mechanism of action?
19. Can the capacity to form a healing relationship be taught or is it a personality trait that is either present or absent?
20. With these questions in mind, what are the best methodologies for the study of healing relationships and their outcomes?

REVIEW OF THE LITERATURE

The term *healing relationship* is not a commonplace in the health professions literature as a review in MEDLINE, CINAHL and PsychINFO demonstrates. Furthermore, of the 84 citations returned using this search term, only 12 were actually related to the relationship between clinician and patient, and of those 12, one was a dissertation using a heuristic, qualitative methodology[6]; none of the rest were data based.[2-17] If, in fact, we look only for previous work on this topic that incorporates all of the concepts included in our definitions, it would be safe to say that the healing relationship is virtually unstudied, with the exception of a good deal of qualitative work in nursing, which will be reviewed below.

Review of the psychology literature using related terms such as *therapeutic relationship*, *therapeutic alliance*, *therapeutic bond*, *empathy*, and others, reveals thousands of articles and hundreds of outcomes studies over many years. This literature essentially concludes that the relationship between the therapist and the client is a stronger predictor of outcome than the actual type of therapy or the extent of the therapist's training.[18-22] A recent meta-analysis of 79 studies of the therapeutic alliance concluded that alliance is moderately related to outcomes of psychotherapy.[23] "The direct association between alliance and outcome identified in this empirical review is supportive of the hypothesis that the alliance may be therapeutic in and of itself. In other words, if a proper alliance is established between a patient and a therapist, the patient will experience the relationship as therapeutic, regardless of other psychological interventions."[23]

Almost exclusively limited to psychological symptoms and psychotherapeutic treatment approaches, this literature may

provide some suggestive directions for our work, but lacks a fundamental compatibility with our focus on the whole person in health and illness and with how clinical practice in nursing actually occurs. The difference between the therapist's weekly 1-hour session over many months and the nurse's intense but typically shortlived involvement is one clear example. Another is the access of the nurse to the body of the patient and the multitude of functions that touch fulfills in the nurse-patient relationship, from the most intimate of encounters in the bed bath to the simple act of holding a grieving parent.

In the medical and nursing literature, a search using the terms *healing relationship* and *outcomes* produced one article,[24] unrelated to our interest here. Searches using the terms *nurse-patient relationship, doctor-patient relationship, therapeutic relationship, patient-centered care, relationship-centered care*, and others, produced some outcomes studies.[25,26] The designs of these studies are typically interpretive, descriptive, or correlational, with few controlled trials. Dependent variables are almost exclusively limited to measures of patient satisfaction and compliance, but there is often a relationship between selected behaviors of healthcare clinicians and these outcomes. Kaplan, Greenfield and Ware[27] reported data collected from 4 clinical trials that demonstrated that "better health" as measured physiologically (blood pressure and blood sugar), behaviorally (functional status), or more subjectively (evaluations of overall health status), was consistently related to specific aspects of physician patient communication. In a few studies some measure of symptom outcome[28] and functional status[29] also is included. Overall, the general suggestion of the literature is that various components of what one might consider to be healing relationships do appear to be related to at least some outcome measures. However, Mead and Bower, in summarizing the empirical literature on patient-centeredness, conclude that "the pattern of findings is somewhat inconsistent, particularly in relation to patient outcomes like health status or satisfaction," and that "it is likely that the more complex and contextual dimensions of patient-centeredness require development of new measures and analytic methods if further advances are to be made."[30]

The caring literature in nursing is closely aligned and consistent with the working definition of the healing relationship articulated by the Samueli Institute as well as with the SIIB definition of healing. The art and science of human caring as developed within the discipline of nursing subsumes many related constructs, such as empathy, compassion, communication, instilling hope, trust, respect, love, patient-centeredness, and relationship-centeredness.

In 1999, Swanson synthesized the literature on caring in nursing science.[31] She reviewed 130 databased articles, chapters, and books on caring published between 1980 and 1996. These included both empirical and interpretive studies. The studies were categorized into the following 5 levels:

- The capacity for caring (characteristics of caring persons),
- Concerns and commitments (beliefs or values that underlie nurse caring),
- Conditions (what affects, enhances, or inhibits the occurrence of caring),
- Caring actions (what caring means to nurses and clients and what it looks like),
- Caring consequences (outcomes of caring).

For the purposes of this exploration, the studies related to *caring conditions* and *consequences* will be summarized.

The category of *conditions* contains papers that explore variables affecting, enhancing or inhibiting caring. "Nurse and patient experiences, backgrounds and/or personalities, society, organizations, health status and disease complications were all identified as influencing whether or not caring transpired."[26(p37)]

Patient-related conditions that influenced the establishment of a caring relationship were categorized as: communication, personality, health problems, care needs, and nurse-patient relationship. Findings suggested that patients who are grateful, who respond favorably, and who are honest about their feelings elicit favorable conditions for caring, while patients who are verbally abusive, unwilling to communicate, and resistive to support do not. Patients who are cheerful, accepting of their illnesses and vulnerability, alert, personable, outgoing, spirited, and courageous, with a will to live, create conditions favorable to caring, while those who are combative, angry, hard to care for, in denial, and unattractive in personality may contribute to conditions in which caring is less likely to emerge. Findings also suggest that patients in pain, with uncertain outcomes, distressed, in crisis, and with psychosocial problems may facilitate a caring response in the nurse, while those with unpredictable problems may not. Based on these findings, it seems that patients with intense needs that can be met are more likely to experience caring than those with needs that may be intense but cannot be met. Finally, some qualities of the nurse-patient relationship, such as congruence in personalities and reciprocal interest, may favor caring, while disagreeable and argumentative relationships do not. In addition, the attractiveness of the patient may be related to conditions for caring.

The *nurse-related conditions* for caring are categorized as resources, constraints, or demands. Findings suggest that positive personal and professional resources, such as past experiences, inner resources, education and competence, contribute to the likelihood that nurse caring will occur. Constraints to caring may be variables like tiredness, stress, feeling unappreciated or disrespected, witnessing death and suffering, or lack of knowledge and skills. Demands on the nurse that might inhibit caring are personal problems, the need to balance home and work, conflicts, and feeling overworked. Organizational-related conditions that affect the occurrence of caring were categorized as personnel or role related, technology, administration, or work or practice conditions. A sense of community or teamwork seemed to be positive conditions for caring. Comfort with reliable technology and an administrative structure and staff that provide support, share governance, and promote communication were essential organizational conditions for caring. Working conditions that inhibit caring are lack of

accountability for nurses, poor staffing, unreasonable workloads, and poor patient care.

Swanson's analysis of the literature on caring consequences has particular importance for this paper. She reports that while some phenomenological investigations support Watson's[32] assertions that caring relationships lead to "betterment of both provider and recipient," there are few quantitative findings that support the outcomes of a caring relationship.[32(p52)] The lack of investigation of patient outcomes of caring is striking and lends support for this initiative. Two studies were identified as relevant exceptions to the lack of empirical work. Latham[33] examined the relationships among patient self-esteem, desire for information and control, nurse caring and the outcomes of appraisals, psychological distress, coping strategies, and effectiveness. "Forty percent of the overall variance in coping effectiveness was accounted for by the combined variables of supportive and sensitive caring, problem and emotion-focused coping and decreased psychological distress."[28(p53)] This correlational study lends support to caring as a contributing variable to the outcome of patient's coping effectiveness.

Duffy[34] studied the relationship between nurse caring, measured by the Caring Assessment Tool, and patient satisfaction, health status, length of stay, and healthcare costs. The only significant correlation (r=.46, P<.001) was between caring and patient satisfaction.

Swanson summarized 30 qualitative studies conducted between 1986-1996 that described outcomes of caring and noncaring relationships. The studies' participants were nurses, patients and their families, students, family caregivers, and other healthcare providers. The outcomes of caring for the recipients of care were: emotional and spiritual well-being (dignity, self-control, personhood); enhanced healing; and enhanced relationships. The consequences of noncaring were identified as feeling humiliated, frightened, out of control, desperate, helpless, alienated, and vulnerable. Significant nurse outcomes were a sense of personal and professional satisfaction and fulfillment. Consequences of noncaring for the nurse were being hardened, oblivious, depressed, frightened, and worn down.

Swanson's NIH-funded investigation of the effects of caring, measurement, and time on women's well being during the first year subsequent to miscarrying is a notable contribution to the caring literature.[35] Using a randomized, controlled, Solomon 4-group experimental design, she determined that women randomized to 3-hour long caring-based counseling sessions experienced less depressed, angry, and overall disturbed moods during the first year subsequent to miscarriage than controls who received no intervention.

In summary, the most extensive database on the concept most closely related to the healing relationship as it is defined in this paper is the literature on caring within the discipline of nursing. There is a wealth of qualitative data suggesting the importance of this relationship to the health and well-being of nurses and their patients and a dearth of outcomes studies to support these qualitative findings.

DEVELOPING RESEARCH ON THE IMPACT OF THE HEALING RELATIONSHIP

Given that there is virtually no previous research on the healing relationship as we have defined it, and that research on the impact of caring, while congruent and inclusive of many elements of the healing relationship, remains primarily qualitative, it is our suggestion that exploratory, observational studies, triangulated with qualitative inquiry, provides the most appropriate starting point for discerning the impact of the healing relationship on selected outcomes. Observational designs, allowing for careful observation and measurement without manipulation of the variables, are consistent with the state of the science in the field; they could be used to address many of the questions for research that we have raised and they are cost effective.[36] Finally, they are consistent with nursing's theoretical frameworks.

Theoretical Frameworks for Investigating the Healing Relationship in Nursing

There are multiple conceptual frameworks in nursing within which the impact of the healing relationship has been or could be explored. Clearly the review of literature suggests that one of these is caring. The caring science framework developed by Jean Watson[2,37-40] has provided a foundation for research, practice and education in nursing since 1979. Watson's framework posits the energetic nature of consciousness, and that the caring consciousness emanates a quality of energy that potentiates healing. The caring/healing relationship preserves human dignity, wholeness, and integrity and is characterized by an authentic presencing and choice. Watson articulates the transpersonal nature of the healing relationship when she defines an instance of it as a "caring moment"[1] in which the soul of the nurse and the soul of the patient come into relationship and are both changed by the interaction.

Other nurse theorists, both before and after Watson, also have explicated the concept of caring as central to nursing. For example, through 3 separate phenomenological investigations of women experiencing perinatal loss, Swanson developed a middle-range theory of caring, which she tested through the randomized study mentioned above.[35] Swanson[41,42] defines caring as "a nurturing way of relating to a valued other towards whom one feels a personal sense of commitment and responsibility."She has defined 5 processes by which caring is enacted:

1. *Knowing* means striving to understand an event as it has meaning in the life of the other;
2. *Being with* is being emotionally present;
3. *Doing for* is doing what the other would do for himself or herself if it were at all possible;
4. *Enabling* is facilitating the other's passage through life events and transitions by providing information, validation, and support; and
5. *Maintaining belief* is sustaining faith in the capacity of the other to get through events or transitions and face a future with meaning.

In the 1999 paper on the state of caring science reviewed above,[41] Swanson provided evidence from 67 separate qualitative investigations of caring actions that suggest her characterization of the caring relationship may be generalizable beyond the perinatal setting.

Margaret Newman's framework offers another related perspective within which the healing relationship can be studied. Newman identifies the need for nursing practice and research to move from a particularistic or deterministic paradigm to a unitary or transformative paradigm.[43] Within the unitary or transformative perspective, Newman suggests, "a phenomenon is viewed as a unitary, self-organizing field embedded in a larger self-organizing field. Change is unidirectional and unpredictable as systems move through stages of organization and disorganization to more complex organization. Knowledge is personal, involves pattern recognition and is a function of both the viewer and the phenomenon viewed."[43] Within this framework, the healing relationship would be explored as a whole system, not as a sum of the parts.

Smith's[44] analysis of the caring literature through a unitary lens resulted in the elaboration of 5 constituents of caring:

- Manifesting intention,
- Appreciating pattern,
- Attuning to dynamic flow,
- Experiencing the infinite; and
- Inviting creative emergence.

These elements may contribute to the explication of the healing relationship as defined earlier in this paper.

Based on a classic qualitative study, Halldorsdottir[45] developed a classification of nurse-patient relationships that forms a continuum from uncaring to caring, and to which we could add, from nonhealing to healing, as follows:

- Type 1 is biocidic or life destroying (toxic, leading to anger, despair, and decreased well-being);
- Type 2 is biostatic or life restraining (cold or treated as a nuisance);
- Type 3 is biopassive or life neutral (apathetic or detached);
- Type 4 is bioactive or life sustaining (classic nurse-patient relationship as kind, concerned, and benevolent)
- Type 5 is biogenic or life giving.

> "This [biogenic] mode involves loving benevolence, responsiveness, generosity, mercy and compassion. A truly life-giving presence offers the other interconnectedness and fosters spiritual freedom. It involves being open to persons and giving life to the very heart of man as person, creating a relationship of openness and receptivity yet always keeping a creative distance of respect and compassion. The truly life-giving or biogenic presence restores well being and human dignity. It is a transforming personal presence that deeply changes one. For the recipient there is experienced an inrush of compassion, often like a current."[45(p44)]

The biogenic relationship, we would propose, is the healing relationship and parallels closely Watson's "caring moment."[3]

Finally, there is the framework of Florence Nightingale, who suggests that it is only nature the ultimately cures (heals) and that the role of the nurse is "to put the patient in the best condition for nature to act upon him."[4(p133)] It seems reasonable to assume that the probable mechanism for the impact of the healing relationship in the healthcare encounter is exactly this—the healing relationship puts the person in the best condition for nature to act on him or her. The human-to-human relationship has the capacity to mediate a host of psychophysiological processes for better or for worse. Miller and colleagues offer a related discussion.[46] Insofar as anxiety, stress, depression, and fear are negative influences on health, then clinician-patient relationships that create these states of body-mind-spirit might be thought of as "unhealing" relationships, or in Halldorsdottir's model, biocidal. The biogenic or healing relationship assists in creating the conditions by which the innate tendency toward the emergence of healing is facilitated and enhanced in terms of renewal, order, increased coherence, and transformation—the Haelan effect in Quinn's[47-50] framework. Here the enormous literature in psychoneuroimmunology, social support, love, and systems and chaos theories can be useful. For example, social support has been shown to affect health status, as has love. The healing relationship might be viewed as a type of critical social support and a particular kind of love offered in moments of intense disequilibrium and vulnerability. It is, perhaps, the added energy in the system that allows the patient to emerge out of the chaos into a higher order—in other words, healing.

Issues in the Design of Studies on the Healing Relationship in Clinical Nursing Practice

1. Research methods need to reflect the nature of the healing relationship

It seems a fair assessment of the literature related to the healing relationship to say that it is particularistic rather than unitary. That is, most studies examined one or more personal characteristics of clinicians, such as empathy, listening behaviors, or communication styles, and then correlated various types of scores on these measures with one or more patient outcomes, usually patient satisfaction, as noted above.

Within the caring/healing frameworks of Watson,[2,37-40] Swanson,[41,42] and others, the unitary-transformative paradigm developed by Newman,[43] and the modes of relationship described by Halldorsdottir,[45] it would seem that the healing relationship is better understood as being more than and different from the sum of its parts. As a living system, adaptive and chaotic, it is nonlinear and acausal. This is also the consensus reached among researchers gathered at the International Workshop on Research Methods for the Investigation of CAM [complementary and alternative medicine] Whole Systems that took place in October 2002 in Vancouver, British Columbia.

While there may be correlates of the presence of the healing relationship, such as warmth, compassion, caring behaviors, empathy and the rest, none of these, especially when isolated from the others, can tell us about the whole, which is a living process occurring within and between 2 whole, unitary human

beings. Furthermore, prescriptive approaches may, in fact, produce the opposite of a healing relationship, creating a sort of script that can inoculate the clinician against the emergence of authentic presence that has been identified throughout the literature as a critical element.

Thus, one major challenge to developing research protocols that can assess the impact of the healing relationship is designing studies that can assess the healing relationship as a whole system. At this juncture it seems reasonable to suggest that exploratory, observational study designs are most appropriate as approaches to provide initial assessments of associations between some measure of the healing relationship and some specified outcomes. Several principles need to guide the selection of research designs within the broad category of descriptive, observational studies.

A. Study of both members of the healing relationship. Such an approach is consistent with a whole systems approach and with nursing's unitary paradigm, allowing for the possibility of actually seeing patterns of the whole system that is the relationship rather then limiting the exploration to one part or the other. Because the healing relationship involves (at least) 2 individuals engaged in a mutual, simultaneous process, it is conceptually incomplete to limit the focus of research on the impact of the healing relationship to only the patient, client, or healee. Clearly, there is a need to understand the experiences of both the healer and healee and their contributions to the dynamic they cocreate. Moreover, the health and well-being of those caring is as legitimate a concern for research on the impact of the healing relationship as that of the ones cared for. The nursing literature is rich in its testimony to the importance of being able to engage in meaningful relationships with patients as a source of satisfaction, joy, and healing for nurses as well as the costs to nurses when such relationship is prevented.

Quinn conducted a descriptive pilot study of both the practitioners and recipients of Therapeutic Touch within this framework and examined psychological and immunological outcomes in both.[51] Of interest to the exploration of the relationship between healer and healee is her finding that each dyad manifested a pattern of time perception and distortion that varied during a series of 7 treatments delivered over 10 days. When one member of the dyad overestimated the length of a treatment, so did the other member. If one underestimated, the other underestimated. Different patterns; ie, overestimating or underestimating, occurred for each treatment session, but the dyad, in 3 out of the 4 dyads studied, always varied together. Inasmuch as the experience of time passing is an index of state of consciousness, it is possible that what was being observed was a correlate of authentic presence and shared consciousness within the healing relationship.

B. Multiple ways of knowing are required to explore the full range of multidimensional questions raised about the healing relationship. Carper's[52] work in nursing provides one such framework that identifies the following 4 patterns of knowing:

- Empirical (5-sense data; the science of nursing);
- Esthetic (taking in the whole; perception; the art of nursing, including empathic acquaintance);
- Personal (an intuitive or subjective way of knowing; relational; encountering and actualizing the concrete, individual self);
- Ethical (the moral component; matters of obligation; the way things ought to be).

An integral model for research on the healing relationship based in Wilber's 4 quadrants of existence[53] is consistent with nursing's caring science framework (see Figure). In this model, there are 4 quadrants, representing a summary of a data search across various developmental and evolutionary fields, including over two hundred developmental sequences recognized by various branches of knowledge—ranging from stellar physics to molecular biology, from anthropology to linguistics, from developmental psychology to ethical orientations, from cultural hermeneutics to contemplative endeavors. They include both Eastern and Western disciplines, as well as premodern, modern, and postmodern sources.[52(p305)]

The 2 quadrants on the right represent the individual (upper-right quadrant) and the collective (lower-right quadrant) dimensions that can be known through the senses or their extensions. Empirical knowing is a product of research originating in 1 of these 2 quadrants. They are objective and interobjective, and exterior. The 2 quadrants on the left are the interior dimensions of the individual (upper-left quadrant) and the collective (lower-left quadrant).

Fully exploring the impact of the healing relationship in nursing will mean that research questions and methods will need to address all 4 quadrants as follows:

- Questions related to the lived experience of the healing relationship for the patient and the clinician as individuals would be upper-left quadrant questions and would require one or more types of qualitative inquiry.
- Questions related to the shared experience of the healing relationship would be lower-left quadrant questions, requiring interview data or correlational approaches.
- Questions related to the impact of the healing relationship on observable, measurable outcomes are upper-right quadrant questions, which lend themselves to quantitative methods and designs.
- Questions related to how the healing relationship is manifested in and impacts on systems of healthcare would be lower-right quadrant questions. Health services research designs might be employed here.

It is our recommendation that research in this new area begin with questions from the upper-right quadrant, which can be addressed through an observational outcomes design, enriched by subjective data that could address the upper-left quadrant perspective; ie, the lived experience of the healing rela-

tionship in both nurses and patients. Therefore, research should include both qualitative, self-report measures and quantitative, observable, third-person measures. Such triangulated designs have a long history in nursing.

2. Measurement tools need to be consistent with the theoretical framework for the study and the conceptual definitions of both independent and dependent variables

A. Measurement related to healing as an outcome (the dependent variable). Measurement of healing, including measures that can indicate healing in the absence of curing, healing as renewal, transformation, or wholeness, requires tools that are consistent with a whole systems approach. Because there are few extant tools that assess healing as a whole as it is defined here, tool development is a critical activity at this stage of the discipline.

There are some tools that, while not specifically measuring healing as a whole, can indicate outcomes that could certainly be seen as aspects of healing and therefore useful to link to the healing relationship. Whatever tools are chosen or developed, rationale should be provided that carefully establishes the validity of the measure relative to the construct of healing as it is being defined here; that is, as more than and different from the cure of physical disease. Table 1 summarizes some of these tools. Of particular note is the McGill Quality of Life Questionnaire,[54-57] with its inclusion of an existential domain in addition to the physical and psychological domains of being. This tool has well-established reliability and validity.

In addition, it is appropriate, particularly because this is a new field of inquiry, to include one or more measures that are typically used in the particular population being studied to measure health-related outcomes so that the contribution of the healing relationships to these standard measures might be assessed.

Finally, global measures with established reliability and validity that are typically used across populations to assess health-related outcomes, such as patient satisfaction with nursing care should be included.[74] The data from such inquiry may ground the findings of the study in a language familiar to practitioners and decision makers across the levels of healthcare administration and management.

Whatever outcome measures are chosen should be presented with a clear rationale that specifies the following:

1. How they are consistent with the conceptual or theoretical framework for the study, or if they are not consistent, why their use is appropriate;
2. Protocols for tool development, including testing for validity and reliability;
3. The patient-centered focus of the measure; that is, if and why this measure matters to patients and justifies the use of their time and energy to provide the data.

B. Measurement related to the caring/healing relationship (the independent or process variable). There are no instruments available that can adequately operationalize the occurrence of the whole of the healing relationship. Extant tools for measuring caring might be useful. Watson's 2002 compendium[76] of instruments for assessing and measuring caring includes tools that measure quality of care, patient and nurse perceptions of caring, caring behaviors, caring abilities and caring efficacy. These 21 instruments, developed by a variety of researchers, can be useful in measuring the extent to which a caring/healing relationship exists, and in this way can contribute to operationalizing the independent variable in the development of impact studies on the healing relationship.

In our review of the literature, we found that the schema presented by Halldorsdottir[45] could quite easily lend itself to the development of a rating instrument for use by both patients and nurses. Individual nurse-patient relationships could be rated from "biocidic" to "biogenic" by both patients and nurses, and these scores could be correlated with selected outcome measures related to healing in patients and satisfaction and burnout in nurses. The Appendix comprises a draft for such a tool, which draws its terms from the extant literature on caring. Scores on this tool also could provide the indication for a qualitative interview with both nurses and patients. If, for example, a particular nurse-patient relationship was scored as biogenic by one or the other member of the dyad, it would be important to collect additional information about what the experience was, what it meant to the reporting person(s) and how the person(s) perceived the effect of the experience. This triangulated design would explore the impact of the healing relationship through questions and methods associated with the upper-right quadrant, the upper-left quadrant, and the lower-left quadrant in the model for integrative research presented earlier.

C. Emergent novel measures. One approach to assessing the quality of the nurse-patient relationship for its healing versus nonhealing impact is by asking patients about their experience of the relationship as suggested above. One might consider that, just as in assessing pain, it is now a given that "pain is what the patient says it is," healing and the healing relationship might be similarly determined.

It also may be possible to observe physiologic processes as a way to assess nurse-patient relationships. Physiologic responses of patients to particular nurses can be measured after the relationship has concluded as a way of obtaining the following information:

- Concurrent validity with paper and pencil scales,
- Unconscious responses,
- Initial indicators of the physiologic correlates of healing,
- Initial indicators of both healing and nonhealing relationships.

For example, Halldorsdottir describes the biocidic relationship as one in which the patient is actually harmed by the practitioner through manipulation, coercion, abuse, humiliation, or other forms of physical, mental, emotional, or spiritual violence. She says "it involves the transference of negative energy or darkness to the other ... the harm done

Potential instruments to measure outcomes of healing relationships in adult populations

Instrument name (abbreviation)	Authors	Description	Language	No. of items
General Well-Being Schedule (GWB)	Dupuy[58]	Measures psychological well-being through representations of subjective well-being or distress	English, possibly other translations	22
Life Orientation Test (LOT)	Scheier, Carver[59]	Measures dispositional optimism or the expectancy to experience positive outcomes	English, possibly other translations	12
Long-Term Quality of Life (LTQL)	Wyatt, Kurtz, Friedman, Given, Given[60]	Measures quality of life for long-term, female cancer survivors; includes spiritual and philosophical views of life	English	34
McGill Quality of Life Questionnaire (MQOL)	Cohen, Mount[61]	Measures quality of life in those with advanced cancer	English	17
Multidimensional Quality of Life Scale (MQOLS)	Padilla, Mishel, Grant[62]	Adapted from Padilla's earlier QLI instrument for people with cancer; measures quality of life in domains of psychological, physical well-being, symptom control, finances	English	27
Psychological General Well-Being (PGWBI)	Dupuy[58]	Self-reports of affective states reflecting subjective well-being or distress	More than 25 languages	22
Purpose in Life Test (PIL)	Crumbaugh, Maholick[63]	Assesses purpose in life based on Frank's theory of meaning	English, possibly other translations	20
Quality of Life Index (QLI)	Ferrans, Powers[64]	Measures quality of life in terms of satisfaction with life	12 languages, including English, French, Spanish, Japanese, Russian, and Swedish	66

Potential instruments to measure outcomes of healing relationships in adult populations (cont'd)

Instrument name (abbreviation)	Authors	Description	Language	No. of items
Quality of Life Scale (QOLS)	Flanagan,[65] modified by Burkhardt[66]	Measures quality of life for those with chronic illness	12 languages including English, German, Swedish, Hebrew, Mandarin Chinese, Danish	16
Schedule for the Evaluation of Individual Quality of Life/ SEIQoL	O'Boyle,[67] McGee,[68] Hickey, Joyce, Browne, O'Malley, Hillbrunner	Assesses quality of life from an individual perspective	English	30
Self-Transcendence Scale (STS)	Reed[69]	Assesses intrapersonal, interpersonal and temporal experiences that reflect expanded boundaries of self	English, possibly other translations	30
Sense of Coherence Scale (SOC-29)	Antonovsky[70]	Measures life's comprehensibility, manageability, and meaningfulness	English, possibly other translations	29
Spiritual Well-Being Index (SWB)	Paloutzian and Ellison[71]	Measures spiritual well-being and existential well-being	English, possibly other translations	20
Spiritual Perspective Scale (SPS)	Reed[72]	Measures saliency of spirituality, the extent that spirituality permeates their lives, and extent of engagement in spiritual interactions	English, possibly other translations	10
WHO Quality of Life (WHOQOL)*	WHO Quality of Life Group[73]	Assesses individual perceptions of the quality of their lives	Available in more than 30 different translations	100
WHO Quality of Life Brief (WHOQOL-BREF)	WHO Quality of Life Group[73]	Assesses individual perceptions of the quality of their lives	Available in more than 30 different translations	26

*WHO indicates World Health Organization.

An integral model for research on the healing relationship. Adapted with permission from Wilber K, Walsh R. An integral approach to consciousness research. In: Velmans M. *Investigating Phenomenal Consciousness: New Methodologies and Maps*. Philadelphia, Pa: John Benjamins; 2000.

depending on the other's strength to endure."[45(p39)] Are there physiologic correlates to this relationship that might be accessible to measurement? Similarly, are there correlates of the relationship that are biogenic? Such measures might contribute to a model that more fully explains what part the provider-patient relationship plays in "putting the patient in the best condition for nature to act upon him,"[4] by telling us something about the inner environment that is created through the relationship.

One way to collect this data would be to use a computer with a simple biofeedback measurement capacity. Patients could be physiologically monitored while they viewed, serially and with appropriate baseline times between, pictures of the various nurses with whom they had relationships during the period being studied. Patients also would complete outcomes questionnaires about each of these nurses on the computer. Responses to the questionnaire assessing a patient's perception of the healing nature of the relationship could be correlated with physiologic data about the same nurse and with the healing outcome measures for a broad overview of the impact of the healing relationship.

3. Preservation of the nature of the healing relationship while trying to study it

Observational studies and naturalistic inquiry, unlike clinical trials, do not attempt to manipulate or change the independent variable. These types of study can minimize, but not resolve the issue of inadvertently affecting the healing relationship. One needs to acknowledge that by the very process of observing (querying, measuring) the relationship, it is changed. Researchers need to address this problem in their designs and be explicit in their decisions regarding how to address these issues. Confounding variables need to be addressed through the design of the research study.

Clinical research in this area is complicated by the vast number of parameters that are outside of the control of the healing dyad. Issues such as staffing, mandatory overtime, organizational structures, discharge or transfer decisions, and other concerns may impact on the nurses' opportunity and capacity to form healing relationships with their patients as well as on the patients' health-related outcomes. Research designs need to acknowledge these variables and describe steps taken to mitigate their impact.

Further Considerations in Designing the Research

1. Participants

An observational study on the impact of the healing relationship in clinical nursing practice could take place in virtually any setting and with any population of patients with whom nurses interact. For example, any hospital could select one of its units, let us say the oncology unit, to explore this question. The research question would be: what is the impact of the healing relationship on (selected) outcomes of hospitalized oncology patients and on their nurses?

Another valuable approach would be to explore this question with several different populations, or across different units in the same hospital, or across similar units in different hospitals, thus illuminating the lower-right quadrant perspective. For example, would patients in hospitals that espouse relationship-centered care experience the nurse-patient relationship as more healing than patients in hospitals without such an emphasis? Would selected outcomes vary across these settings?

Whatever participants are selected, rationale related to the questions for study, as well as eligibility criteria and methods for recruitment, should be specified.

2. Specific objectives and hypotheses

Specific objectives should be presented in the form of research questions, as in the following example: Is there an association between how oncology patients rate the healing quality of their relationships with nursing staff and patient satisfaction with nursing care following discharge? Hypotheses that include the specific data to be collected should be specified as the basis for data analysis. For example, from the research question/objective above, a testable hypothesis would be the following: At 48 hours postdischarge, oncology patients who rate at least one nurse-patient relationship as healing on the healing-relationship scale have higher scores on the patient-satisfaction-with-nursing-care questionnaire than patients who do not rate any nurse-patient relationship as healing.

3. Sample size

The sample size for the study should be specified, along with a discussion of how the number was determined. Recognizing that ideal sample sizes are not always possible to obtain in clinical nursing settings, the sample should be large enough to have sufficient power to detect a statistically significant association between the independent and dependent variables if, in fact, an association exists.

4. Statistical methods

Specific methods for analyzing the data should be presented for each hypothesis, along with a rationale for the appropriateness of their use. If there is to be additional analysis, for example, to include qualitative data derived from interviews, then methods for collecting and analyzing these data and ensuring rigor also should be specified.

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APPENDIX: DRAFT OF A NURSE-PATIENT RELATIONSHIP QUESTIONNAIRE

Jane Doe, RN 	1. Choose one: ☐ This nurse took care of me. ☐ This nurse did not take care of me.
Jane Doe, RN 	2. Looking at this picture makes me feel (CHOOSE ONE): ☐ Cold and disgusted ☐ Sad ☐ Nothing ☐ Warm and peaceful ☐ Deeply moved
Jane Doe, RN 	3. How CONNECTED to this nurse did you feel (CHOOSE ONE): ☐ Very unconnected ☐ Somewhat unconnected ☐ Neither connected nor unconnected ☐ Somewhat connected ☐ Very connected
Jane Doe, RN 	4. In my relationship with this nurse, I felt that my **DIGNITY** was (CHOOSE ONE): ☐ Destroyed ☐ Hurt ☐ Unaffected ☐ Preserved ☐ Enhanced
Jane Doe, RN 	5. In my relationship with this nurse, I felt that my **PHYSICAL WELL-BEING** was (CHOOSE ONE): ☐ Destroyed ☐ Hurt ☐ Unaffected ☐ Preserved ☐ Enhanced
Jane Doe, RN 	6. In my relationship with this nurse, I felt that my **EMOTIONAL WELL-BEING** was (CHOOSE ONE): ☐ Destroyed ☐ Hurt ☐ Unaffected ☐ Preserved ☐ Enhanced

APPENDIX: DRAFT OF A NURSE-PATIENT RELATIONSHIP QUESTIONNAIRE

Jane Doe, RN 	7. In my relationship with this nurse, I felt that my **SPIRITUAL WELL-BEING** was (CHOOSE ONE): ☐ Destroyed ☐ Hurt ☐ Unaffected ☐ Preserved ☐ Enhanced
Jane Doe, RN 	8. In my relationship with this nurse, I felt that my **HEALING** was (CHOOSE ONE): ☐ Destroyed ☐ Hurt ☐ Unaffected ☐ Preserved ☐ Enhanced
Jane Doe, RN 	9. In my relationship with this nurse, I felt that my **SENSE OF WHOLENESS** was (CHOOSE ONE): ☐ Destroyed ☐ Hurt ☐ Unaffected ☐ Preserved ☐ Enhanced
Jane Doe, RN 	10. In my relationship with this nurse, I felt that my **SENSE OF SAFETY** was (CHOOSE ONE): ☐ Destroyed ☐ Hurt ☐ Unaffected ☐ Preserved ☐ Enhanced
Jane Doe, RN 	11. If I were hospitalized again, I (CHOOSE ONE): ☐ Would never allow this nurse to care for me ☐ Wouldn't like this nurse to care for me ☐ Wouldn't care if this nurse cared for me or not ☐ Would want this nurse to care for me ☐ Would be thrilled to have this nurse care for me
Jane Doe, RN 	12. Words I would use to describe this nurse are (write in as few/many as you like):

APPENDIX

CHECKLIST Quality guidelines for developing a research protocol to assess the impact of the healing relationship in clinical nursing practice

Protocol Section	Criteria
Title and abstract	The title clearly identifies the study as an observational or impact study focused not on efficacy but on assessment of the impact of the healing relationship in clinical nursing practice. The term *healing relationship* appears in the title so that the healing relationship as field of study begins to become more widely recognized and so that the study may be easily located by future researchers. The abstract is structured so that the objective(s), design, setting, participants, and main outcome measures are easily identified.
Scientific background and explanation of rationale	Research on this topic expands one or more of the rationales offered in this paper, or another rationale is offered to justify the significance of the study. Following this discussion, a rationale is offered for the particular approach taken in the study, based on extant literature and related theories, where appropriate. Specific questions about the healing relationship, which the study will help to answer, are presented in either question form or as objectives or aims. The list of 20 questions provided earlier in this paper is not exhaustive, but may assist researchers in focusing their inquiry. Independent and dependent variables are defined and rationales provided for their selection, grounded in extant nursing and related theoretical frameworks.
Methods	A rationale is provided for the methods and design chosen based on theoretical rationale and questions for study.
Research methods need to reflect the nature of the healing relationship.	• The study includes both members of the healing relationship; ie, nurses and patients. • Multiple ways of knowing are used; ie, both quantitative and qualitative data are collected.
Measurement tools need to be consistent with the theoretical framework for the study and the conceptual definitions of both independent and dependent variables.	• Measurement tools are fully described and a rationale for their use is presented. • Any tools developed are described, including a rationale and any measures taken to establish validity and reliability.
Preservation of the healing relationship while trying to study it	The study includes a discussion of issues related to preserving the healing relationship. Measures taken to minimize disturbance are described.
Confounding variables need to be addressed through the design of the research study	Confounding variables particular to the setting and population being studied are identified. Measures taken to mitigate their effects are described.
Participants	Eligibility criteria and a rationale for selecting nurse and patient participants are provided. The setting(s) for data collection are described.
Specific objectives and hypotheses	Specific objectives are presented in the form of research questions. Where appropriate, hypotheses that include the specific data to be collected are specified as the basis for data analysis.
Sample size	The sample size for the study is specified, along with a discussion of how the number was determined and how participants will be recruited.
Statistical methods	Specific methods for analyzing the data are presented for each hypothesis with a rationale for the appropriateness of the methods' use. If additional qualitative data are needed, then methods for collecting and analyzing these data and ensuring rigor also are specified.