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Application of Jean Watson's Theory of Transpersonal Caring in Nurses Practicing in a Pain Center

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in Nurses Practicing in a Pain Center

by

Patricia Malone Hubert

DNP Scholarly Project Committee

Dr. Mary Ellen E. Roberts, Chair

Dr. Mary Patricia Wall

Dr. Patricia Clark Pappas

Karen Macey-Stewart, MSN, RN-BC

Submitted in partial fulfillment of the Requirements for the degree of

Doctor of Nursing Practice

Seton Hall University

2018

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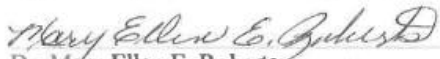
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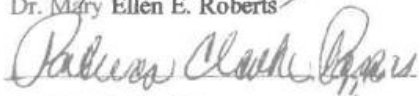
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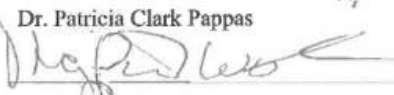
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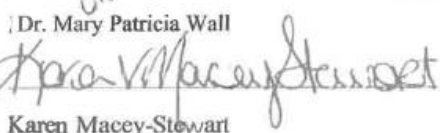
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Dedication

I dedicate this work to those who have influenced my past and present and those who will hopefully benefit from it in the future. As to my past, it is with profound appreciation to my first teachers, Arthur and Regina Malone, that I dedicate my work. You nurtured my body, mind and spirit. You modeled love, hard work, sacrifice and caring for others.

On to the present and past that I live with, my wonderful husband, Joseph M. Hubert, Jr., you followed me to Seton Hall, and became my best friend and husband of 45 years! You are the one who made my doctoral study possible in many ways. Thanks for everything!

To my Seton Hall College of Nursing family: you laid a solid foundation for nursing practice under the leadership of Dean Agnes Reinkemeier, whose passion for the profession continues to inspire me. To the nursing legends who taught me and colleagues who have sustained me, I am most grateful. To the nursing students, you too have taught me, while I modeled continuous learning by pursuing my doctorate when others chose retirement.

To a special group in the past, present, and future categories, my children: Janine Hubert Faux, Joseph M. Hubert, III, Faith Hubert Horton and Elise Hubert Klug. You are the accomplishment of which I am most proud! To all of my wonderful “grands,” know that I delight in you, and look forward to the grown-ups you will become. There is always more to learn.

To those with chronic pain, I applaud your strength and bravery! As facilitator of the Union/Essex Chapter of the American Chronic Pain Support Group for eight years, I’ve learned your struggles and successes. Your unmet needs propel me; they must become visible in society in order to be understood. So this project is dedicated to you and the nurses who care for you. In the future, may your needs be better met, and may your suffering be less.

Acknowledgments

This journey toward a project required a recalibration of route and special thanks must go to Dr. Judith Lothian for steering me in the direction of Jean Watson's Human Caring Science Theory. I was a solo traveler until the kindness of my cohort partner, Mary McDermott, introduced me to the New York State Caritas Consortium. This has opened an avenue toward a deeper understanding of the Human Caring Science Theory of Nursing and thus aided the planning of this project.

Dr. Mary Ellen Roberts, your encouragement, along with Dr. Jane Dellert during the interview process was appreciated. Your challenging course of study has stretched me. My expert advisor, Karen Macey-Stewart, I am grateful for your knowledge and friendship. My readers, Dr. Patricia Clark Pappas and Dr. Mary Patricia Wall, your time and expertise were essential to fine-tuning this document.

Dr. Maureen Schneider's role was pivotal: she provided the opportunity to implement my project in the hospital where she serves as Director of Nursing (DON). Her direction, guidance and encouragement were essential to the success of this endeavor. Kudos to the nursing administrators of the Pain Center for striving to implement change. To the staff nurses, it was a privilege connecting with you. Thanks for being open to change in your personal and professional life. Last, but not least important, was the interest of my family and friends in all areas of my life. Thanks for cheering me on! Your dialogue sparked some of my best thinking. Special thanks to Kristen Hubert and Joanne O'Neill for your support. My gratitude to all who helped inspire and sustain me on my own journey of transcendence, including my colleagues at Seton Hall University Mission and Catholic Studies.

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Abstract

The aim of this project was to determine if an educational intervention utilizing Jean Watson's Theory of Human Caring influences nurses' level of awareness and practice of loving kindness to self and others. Watson's paradigm of transpersonal caring is presented as a means to provide the compassionate care needed by patients with chronic pain, who are vulnerable to the comorbidities of depression and anxiety and often have poor outcomes. This quality improvement project was implemented with five Registered Nurses working in a pain center. A two-pronged intervention was structured to begin developing a Caritas Consciousness in Session 1 by focusing on the nurse, applying Caritas #1, loving kindness, to self before applying it to others. Mindfulness, meditation and reflective journaling cultivated their personal journey for several weeks. In Session 2 the focus shifted to the needs of the patient, applying Caritas #1 and #6 with patients in chronic pain. Session 3 allowed time for discussion of ways to grow and sustain a healing environment. Self-reporting of nurses' perceptions of their caring pre- and post-educational intervention was obtained via surveys. The *Watson Caritas Self-Rating Scale*, a tool with demonstrated validity and reliability, showed an increase in each of five components of self-caring with a mean increase overall. This indicates movement in a positive direction toward the loving-kindness initiative. The *Self-Rating Survey of Caring*, designed and piloted for the nurses to rate self on each of the ten Caritas Processes, showed an increase for each item and a mean increase overall. A *Post-Survey for Nurses* showed positive ratings on all 12 statements. The educational intervention helped the nurses begin a journey which should lead to improved compassionate care. The Caritas #1 component of this project is a model which can be replicated with nurses in any setting. Focusing on one Caritas Process to meet the specific needs of a patient population can also be replicated.

I. BACKGROUND

a. Introduction

A comprehensive literature review search for evidence on chronic pain management was conducted utilizing the following databases: CINAHL, Cochrane, Medline, and PsycINFO within a 10-year period.

Chronic pain is a major problem worldwide, with more than 1.5 billion people worldwide suffering from chronic pain and approximately 3-4.5% of the global population suffering from neuropathic pain, with incidence rate increasing in complementarity to age (The American Academy of Pain Medicine, 2011). Population level surveys indicate that between 11% and 40% of the U.S. population report some level of chronic pain, with millions suffering from daily, severe, and disabling pain according to the National Pain Strategy (NPS) written by the Interagency Pain Research Coordinating Committee (2016, p. 13). At least 116 million U.S. adults are burdened with chronic pain (Institute of Medicine, [IOM], 2011). It affects more Americans than diabetes, heart disease, and cancer combined (the Academy of Pain Medicine, 2018).

Pain is recognized as an “unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage” (International Association for the Study of Pain [IASP], 2017, para. 1). Chronic pain was defined in the past as pain lasting over six months, but now as persistent or recurrent pain lasting longer than three months (Treede, 2015). The IASP Task Force of 2004 defined it as pain with no biological value that persists past normal tissue healing (Mersky & Bogduk, Eds., 2004).

Chronic pain is a leading cause of disability, and high rates of depression and anxiety occur in this population (Katz et al., 2015). It is frustrating not only for the patient, but their significant others and health care providers, which often requires considerable effort and poses

challenges to effective care delivery. The patient with chronic pain seeks relief, and when not achieved, they experience further stress, and can become irritable, and demanding, creating a challenging and potentially taxing work environment for nurses practicing in a pain center.

Nurses frequently encounter persons with chronic pain, but they may lack the knowledge needed to best help. The fact that chronic pain has multiple causes complicates the situation, as do additional issues detailed in the literature review below. To explore methods in which nurses will be better able to help patients with chronic pain, a nurse expert in pain management, also an Advanced Practice Nurse (APN) who manages an in-patient pain service at a local community hospital, agreed to serve as mentor in this project.

Jean Watson's Theory of Human Caring (2008) was selected as the theoretical basis of this project. Application of her theory in a novel way with nursing staff at the Pain Center actually became the project since the theory guided the intervention. This educational intervention was designed to help nurses deepen their understanding of Watson's theory and learn to live it, by first embracing a Caritas Consciousness, using Caritas #1, loving kindness, in their own life, before extending it to others, and using it to help their patients with pain via transpersonal caring. The initial focus was on self-care and mindfulness practice over several weeks, which was planned and implemented. Later sessions focused on Caritas #6, using the self in all ways of being and knowing and being open to all modalities, to assist the patient in pain. This is a demonstration of Essential III: Clinical Scholarship and Analytic Methods for Evidence Based Practice (AACN, 2006). As Chism (2013) states, "DNP graduates are in a distinctive position to merge nursing science, practice, human needs, and human caring" (p. 15). A site for implementation was sought at a small community hospital. Upon phone consultation with the Director of Nursing (DON), she expressed interest in having someone work with the nursing

staff of the Pain Center to facilitate application of Watson's theory to the clinical setting.

Guidance was sought from *Caring Science, Mindful Practice* (Sitzman & Watson, 2014) which illustrates ways this has been done in various clinical settings, bridging the gap between the theoretical and the practical. An outline of Watson's basic concepts was formulated to determine how to best implement Watson's theory, using each of the Caritas Processes to improve the care of patients attending the Pain Center. The importance of mindfulness to Caritas was recognized since Caritas is the Latin word for "cherish"; to appreciate and give special, if not loving attention to. It represents compassion and generosity of spirit (Watson, 2008). Jon Kabat-Zinn (1990) states "Simply put, mindfulness is moment-to-moment awareness. It is cultivated by purposefully paying attention to things we ordinarily never give a moment's thought to. It is a systematic approach to developing new kinds of control and wisdom in our lives" (p. 2).

In a subsequent meeting with the DON, the supervisor of the outpatient surgical area, which includes the Pain Center, and the Pain Center nurse-manager, their desire to increase nurses' literacy of Watson's theory was voiced, as it is part of the hospital's vision. Discrepant levels of literacy among staff throughout the hospital were reported, with most nurses at a beginning level of understanding. This helped to establish the "buy in." There was particular interest in self-care for the nurses, especially mindfulness. All seemed enthusiastic at the prospect of increasing nurses' knowledge of the use of Jean Watson's theory as the hospital strives for Magnet status. Two Caritas Processes were selected with these nurse administrators as the focus of this project: Caritas #1, using mindfulness as a way to be in "right-relationship" with self, and Caritas #6, helping nurses understand the chronic pain experience, using all ways of knowing and being, and helping with their decision-making when considering all modalities.

This meets DNP Essential II: Organizational and Systems Leadership for Quality Improvement and System Thinking, since it was designed to meet the needs of a patient population.

A later planning meeting was held with the nurse-manager. A timeline was developed and shared with the nurse-manager who was scheduling the proposed sessions with the staff. An expedited Institutional Review Board approval was required for Atlantic Health, so the proposal was first presented to the DON, followed by presentation to the Nurse Research Council on May 10, 2017. Approval was received two weeks later and further planning commenced.

b. Description of the Project

This project is an attempt to make a positive change in a small setting by focusing on the needs of the nurses, to ultimately improve the delivery of care to patients attending a Pain Center. It was designed to highlight the importance of the care and compassion needed by these patients. Jean Watson has developed a theory of nursing, and extended it to include other disciplines, based on caring. Caritas #1 explains that in order to practice loving care and kindness to others, one must first practice loving kindness of self. Achievement of Caritas #1 and having a “Caritas Consciousness” were the goals for this project, as well as learning about the needs of the patient with chronic pain and having a readiness to employ Caritas #6. Jean Watson’s paradigm of transpersonal caring is presented as the means to an end—that is, the highest quality care for these patients. Watson states “The mode of Caritas thinking invites a total transformation of self and systems” (2008, p. 36).

To move toward this aim, a Quality Improvement (QI) project was designed to be implemented with Registered Nurses practicing in a pain center. Content focused initially on nurses in Session 1, followed by patient needs in Session 2. The importance of self-care for

nurses is cited in the literature (Crane & Ward, 2016; Myers, 2017). However, being knowledgeable regarding the importance of health-promoting activities does not always translate into nurses' own self-care (Ross et al., 2016). Nurses often sacrifice their own needs to care for others, yet nurses must take care of their own needs in order to sustain optimal ability to care for their patients, according to Myers (2017). Meeting the needs of nurses themselves should help them to care for others. Kret (2011) explicates the concept of compassion as a reaction to empathy and states "A better understanding of the patient must be reached in order for the nurse to care for the patient in an effective, meaningful way" (p. 29). Therefore, gaining insight into what happens to a person with chronic pain should facilitate empathy and compassion on the part of the nurse.

Based on the literature and experience with patients with chronic pain, an assumption was made that there was room for improvement in the care of such patients. The stated problem is: Nurses in the Pain Center have a need for more education in Watson's Theory of Human Caring as well as practice in using the Caritas Processes. This project aimed to help nurses become increasingly self-aware and practice loving kindness to self and others. The potential benefits for the nurses themselves are supported by the literature review, as well as the expectation that this would help nurses be in a better position to enter into a transpersonal caring relationship with patients in pain. This is also supported by the literature. The expectation is that the nurses will improve in their self-reported Caritas Consciousness, use of the ten Caritas Processes, and particularly Caritas #1 and #6. Activities for each session and outcomes are described.

Utilizing Jean Watson's Human Caring Science theory, a program focusing on the nurse was created for Session 1. In the session, nurses were affirmed for who they are and the work

they do, and the importance of self-care was emphasized. Nurses were taught how to meditate and engaged in a 10-minute guided meditation using an audio recording by Jean Watson. They were started on a journey of Caritas at this Nurses' Centering Orientation. A brief educational PowerPoint (PPT) presentation (Appendix A) was presented which described the evolution of Watson's theory, and the continuum from uncaring to caring was explained with an introduction to the concept of transpersonal caring. All ten Caritas Processes were presented, as well as the need for both nurse and patient to achieve harmony and strive for transcendence. An Emphasis was placed on Caritas #1: Cultivating the Practice of Loving-Kindness and Equanimity Toward Self and Other as Foundational Caritas Consciousness. This consisted of practicing mindfulness, which can be cultivated by practicing meditation, learning how to respond to stress instead of reacting to it, using touchstones to set intentionality, and the importance of developing skills to center oneself when stressed. The nurses were challenged to reflect on how they show loving kindness to themselves. Reflective journaling as a tool for self-assessment and growth was introduced. They were asked to perform a self-assessment later that day and write in the personal journal provided. Questions to guide their initial reflection were: "Do you visualize your life as a dot or a line?" Discussion then focused on envisioning life as a dot to help one become mindful, with life reimagined as a series of dots, or moments. Another question, "Do you live in the moment—in awareness of what is at that moment, or are you always thinking of the future moments?" The rationale for this question is that one needs to consider this concept and practice in order to live in the moment. The following question was provided to guide their initial self-evaluation: "Do you take the time and space for emotional self-care, physical self-care, mindfulness, forgiveness and spiritual self?" Their responses would help them formulate personal goals for the next week and six weeks after that on this journey of increased self-love.

Materials were distributed to further educate the nurses on self-care and Watson's theory, with a focus on Caritas #1. A handout (Appendix B) containing suggestions for this via self-care was provided. Guidelines for applying Caritas #1 were developed and provided (Appendix C). Guidelines for meditation, journaling, and use of touchstones were included, in addition to a copy of four professional nursing journal articles about mindfulness and self-care to be read at their leisure. Because the opportunity to meet with the nurses was limited, a means to maintain contact with them was created via email group. Weekly reminders were sent to provide affirmations and encouragement on their journey of reflection and renewal.

For Session 2, an educational PPT (Appendix D) was created to provide the nurses with an overview of the needs of the patient with chronic pain and how to address these needs utilizing Caritas #6: Creative Use of Self and All Ways of Knowing as Part of the Caring Process; Engage in the Artistry of Caritas Nursing. An attempt was made to provide a comprehensive educational session addressing ways the patient in pain's experience is viewed from varied perspectives. Unfortunately, the presentation contained 131 slides and was deemed too large for a one-hour session. A judgment was made to leave slides in the PPT for reference purposes, but the instructional session emphasized the patients' experience, how pain changes a person, the various modalities and how the nurse can use Watson's transpersonal caring to best help the patient—all elements for applying Caritas #6. The illustration of the transpersonal caring theory (Appendix E) which generated interest at Session 1 was again a focal point for the nurses. A handout was created (Appendix F) which outlines the use of Caritas #6. Supplementary materials were provided including three nursing journal articles. A third session was held to allow time for further discussion of linking Caritas #1 and #6 and for discussion.

c. Purpose of the Project

This project provided the opportunity to utilize the current state of knowledge synthesized from research regarding nurses' use of Watson's theory in working with patients with chronic pain. Providing nurses with evidence of the effectiveness of various modalities to address care of the patient with pain fulfills an emerging need and direction for nurses to improve their practice. The nurse has an important multifaceted role with such patients who often feel isolated and stigmatized. The nurse can be authentically present so they do not feel alone on this journey. The nurse can provide information about modalities which might help, and also help them cope. The patient can be guided to understand and accept that in many cases complete pain relief may not be possible. The nurse can help identify realistic goals with the patient and physician related to pain relief, function, quality of life and life satisfaction.

This project focused on the use of Jean Watson's transpersonal caring to help the patient with chronic pain. Toward this end, the nurses were educated about the theory in general, with a particular emphasis on Caritas #1 which should assist them to be in what Watson calls right-relationship with self. Turkel & Ray (2004) remind us "As nurses struggle in their wounded state, compassionate caring holds the key to the meaning of suffering within ourselves and others" (p. 250). Learning about transpersonal caring should be valuable to nurses who desire to care for their patients with compassion. As Jean Watson notes in describing transpersonal caring states,

The transpersonal nature of the experience is connected with the nurse's ability to be authentically present in a way that reaches out to the other, transcending ego. This is the source of compassion, when one is able to connect transpersonally. (2008, p. 78)

Caritas #6 should help the nurses see the shift toward Caritas Coaching, which Watson calls a more advanced approach to teaching-learning, Caritas #7, in which the nurse serves more

as a sojourner and a resource. “In other words, the person becomes his or her own best problem solver; the individual is his or her own best source for finding unique creative solutions for meeting goals and a vision for change” (2008, p. 127). More linkages of practice with theory are explained in Theoretical Framework below.

d. Goals and Objectives

The short-term and intermediate goals were sought during project implementation. The short-term goal was that nurses will practice daily centering 10 minutes/day along with reflective journaling six days/week. This will promote the achievement of the intermediate goals, which are expected within two months of commencing implementation:

- 1) Nurses become increasingly self-aware and practice loving kindness to self and others; it will become a habit.
- 2) Nurses will display increased knowledge of Watson’s theory.
- 3) Nurses will display a “Caritas Consciousness.”
- 4) Nurses will be in better position to enter into a transpersonal caring relationship with patients in the Pain Center.
- 5) Nurses will be knowledgeable in ways to assist the Pain Center patients with coping using varied methodologies.

This project could have positive effects which would promote further changes on the unit and perhaps extend to other units in the hospital. To be sustainable, further effort within the staff of the Pain Center will be needed. The long-term goals are for future direction:

- 1) The Pain Center will be a healing environment in which the nurses will treat all patients, at all encounters with transpersonal caring.
- 2) Nurses will be on an established Caritas journey.

It was recognized that a successful first session would be important to stimulate the nurses' interest in order to achieve these goals.

e. Significance of the Project

Nurses are vital in the desired cultural transformation from focusing on “the cure” to focusing on “the care” which has been called for by the Institute of Medicine (IOM, 2011). Use of Watson’s transpersonal caring by the nurse should make a difference to the patient who has chronic pain. The nurse may not be able to eliminate the pain and suffering, but can help lessen the pain and be instrumental in lessening the suffering, thus reducing the total burden of the pain. Importantly, the nurse can guide the patient in self-management. Just as pain is biopsychosocial in nature, so its treatment should be also. Slatyer et al. (2015) found that engaging with patients enabled nurses to understand their pain relief needs and preferences, to implement feasible treatments and provide emotional support. They further described empowerment as a both a process and an outcome for both the patients and nurses. Pain has many causes with many trajectories, and there are varied individual responses to pain, which may be genetically influenced. There is no one-size-fits-all treatment. Multiple modalities are likely more successful than monotherapy because pain is approached from all angles, and this approach has been recommended to optimize patient outcomes by multiple physicians, nurses, psychologists, study groups, expert panels and professional associations (Caudill, 2016; Fine, 2011; Gatchel, 2002; Kirsh et al., 2011; Thorn, 2007; Williams et al., 2007; NPS, 2016; Wells et al., 2008; The American Society for Pain Management Nursing, 2015; The American Academy of Pain Medicine, 2017). Patients themselves may be best positioned to manage their own pain, but often need more knowledge and support on this journey (Caudill, 2016). Many modalities work synergistically, but patients need help to navigate the maze of information and misinformation,

to overcome barriers and find the right resources and combination for themselves (Drake et al., 2017). Having a nurse partner with them on their journey could make all the difference.

The recent increased regulation and caution with regard to the prescription of opioids has placed attention on non-pharmacologic methods as alternative ways to ease pain. Thus, it is timely and important for nurses to possess as much knowledge as possible about these methods, in order to assist their patients. The perspective of Eastern medicine has much to offer but nurses often lack an understanding of these modalities. Nurses can take the lead on the health care team in this regard. Human Caring Theory (Watson, 2012) guides the nurse to act creatively, and with a mind open to all possibility. This is an opportunity for nurses to demonstrate the full range of their ability to contribute by developing the nurse-patient relationship to the point of actually *becoming* the environment for the patient.

II. REVIEW OF THE LITERATURE

What We Know About Chronic Pain

While pain has plagued mankind since the beginning of time, our understanding of it, and of chronic pain, in particular, is relatively new. “The experience of pain is a complex amalgam maintained by an interdependent set of biomedical, psychosocial, and behavioral factors, whose relationships are not static but evolve and change over time” (Turk & Monarch, in Turk & Gatchel, 2002, p. 23). The assessment and treatment of pain remains an essential part of nursing care and was incorporated into the Clarification to Standard PC.01.01.07 by The Joint Commission (TJC), 2015. In 2012, TJC reported 75% of clients have unrelieved pain (Kee, Hayes & McCuistion, 2012, p. 361). The expert panel required by Section 4305 of the Affordable Healthcare Act of 2010 observed in their report *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research*, IOM (2011), that

“Much of what we already know is not applied well or consistently in clinicians’ day to day interactions with people in pain” (p. 2). They see it as a moral imperative, stating “There is a crisis in the impact of and response to pain in America” (p. 2). Nineteen gaps were identified in policy, treatment, attitudes, education, and research; they were charged with studying why and how these might be remedied. Chronic pain, they note, is maladaptive and results in many changes in the peripheral and central nervous system that aid in its persistence, and “Because of those physiological changes, some types of chronic pain are diseases in their own right” (IOM, 2011, p. 2). Furthermore, Wells et al. (2008) explain that untreated pain can lead to chronic pain later (p.1).

Chronic pain is a disease, and needs to be managed as such, with efforts toward secondary prevention as called for in *Healthy People 2020*. The way people construct the meaning of pain and the ways they cope with it are important, according to Williams et al. (2007), who state “The efficacy of multidisciplinary chronic pain management programs to decrease pain, increase functioning and enhance overall quality of life is well documented (Williams et al., 2007, p. 133). Kirsh & Fischman (2011) note multimodal approaches optimize outcomes of chronic pain. The IOM (2011) and IPRCC (2016) recommend interdisciplinary care, provided by a team of health professionals from diverse fields who coordinate their skills and resources to meet patient goals using multiple modalities. But neither multidisciplinary nor interdisciplinary care may be a reality in many parts of the U.S. This is counterintuitive, because just as the causes and maintenance of pain are holistic, the management should be as well. Approaches should deal with the whole patient, be patient-centered and consider individual preferences (IPRCC, 2016). In the past, the biomedical has been the sole focus, but that needs to change to a biopsychosocial approach. Presently overall outcomes are often poor as pain

becomes the person's focus, and their function and social interactions become limited. Use of Watson's transpersonal caring by the nurse should make a difference to the patient who has chronic pain. The nurse may not be able to eliminate the pain and suffering, but can help lessen the pain and be instrumental in lessening the suffering, thus reducing the total burden of the pain. Attention to prevention is also needed and seems critical due to the dynamic nature of pain. The new neuroscience informs us that pain changes the brain. The concept of "neural plasticity" informs us that neurons can change their structure, function and chemical profile in response to pain, causing modulations in the short term and modifications in the long term (Thorn, 2004). Chronic pain has the capacity to become increasingly complex in its pathophysiology, and potentially more difficult to treat over time according to Fine (2011). As with other chronic conditions it should be managed to minimize or avoid associated sequelae, improve outcomes and return patients to normal level of function.

Inadequate pain relief is a safety issue for many reasons. Unrelieved pain leads to a multitude of harmful effects involving almost all organs of the body (Kee, Hayes & McCuiston, 2012, p. 363). Because of sustained increases in heart rate, respiration, and blood pressure, the effects on the cardiovascular system can be significant. There are also risks to mental health in the chronic pain population. Braden & Sullivan (2008) noted psychiatric comorbidity was common among persons with a pain condition, most commonly depression and anxiety. In addition, chronic pain exerts a significant and enduring effect not generally seen with non-painful conditions. They observe that disability and functional impairment may precipitate depression and suicidal thoughts, but that pain alone is unlikely to lead to suicidality, even if severe and persistent, unless it is combined with depression or catastrophizing that prompts hopelessness about the future. They note any self-reported pain condition was associated with

approximately 40%-50% additional increase in risk of lifetime suicidal ideation, plan or attempt (Braden & Sullivan, 2008, p. 1112). Nurses need to identify patients at risk in order to intervene.

In addition to this safety issue, inadequate relief of chronic pain is a major contributor to a downward spiral of disability and dysfunction that is experienced by so many individuals with chronic, unrelenting pain (Thorn, 2004). Chronic pain is a leading cause of disability and outcomes are often poor: pain becomes the focus, function becomes limited, and social interactions limited. Inadequately treated chronic pain causes harm.

Watson's Theory of Human Caring

Jean Watson's theory appeared in 1979 to bring new life and dignity into the profession (Watson, 2008). She considered and incorporated elements of the other nursing theoretic frameworks from Florence Nightingale to the present day, particularly those on caring.

Watson (2012) cited Halldorsdottir's (1991) continuum from uncaring to caring and states

The biogenic caring represents the highest level of caring related to healing, wholeness, and a transpersonal caring relationship in that both nurse and patient are affected by the relationship. . . . A truly life-giving presence of being open and giving from the heart, receptive with respect, compassion, and dignity, creating a trusting relationship that is human-to-human. (Watson, 2012, p. 45)

This is the trusting and healing nurse-patient relationship desired by Watson. She introduced the Carative Factors as a theoretical counterpoint to the notion of Curative in medical science. She identified what comprised the "core" or unchanging essence of professional nursing practice, as opposed to the "trim," which is necessary, task-oriented, and constantly changing. Attention was given to a person's energy, the environment and the cosmos. Intentionality and consciousness were advanced along with an emerging focus on transpersonal caring to restore the possibility of human transcendence (Watson, 2002).

In 1985, in response to the evolving state of knowledge in the sciences, the arts, and humanities as well as the nursing profession, plus research and personal development, Watson's insights led to revising the theory. She proposed in 1999 an ontological shift in consciousness with a return to the sacred core of humankind, inviting mystery and wonder into our lives, work, and world (Watson, 2008, p.7). In 2005 additional attention was placed on the spiritual and the sacred as seen in her book *Caring Science—Sacred Science* (Watson, 2005). She extended the theory in 2008 from Carative Nursing to Caritas Caring Science with its "expanded cosmology of unity, belonging, and infinity of the universal field of Love" (Watson, 2008, p. 33). At that time the original ten Carative factors which comprise the theory were transposed and extended into the new language of Caritas.

The Caritas Processes are listed below:

1. Cultivating the Practice of Loving Kindness and Equanimity Toward Self and Others as Foundational to Caritas Consciousness
2. Being Authentically Present: Enabling, Sustaining, and Honoring the Faith, Hope, and Deep Belief System and the Inner-Subjective Life World of Self/Other
3. Cultivation of One's Own Spiritual Practices and Transpersonal Self, Going Beyond Ego-Self
4. Developing and Sustaining a Helping-Trusting Caring Relationship
5. Being Present to, and Supportive of, the Expression of Positive and Negative Feelings
6. Creative Use of Self and All Ways of Knowing as Part of the Caring Process; Engage in the Artistry of Caritas Nursing
7. Engage in Genuine Teaching-Learning Experience That Attends to Stay Within the Others' Frame of Reference
8. Creating a Healthy Environment at all Levels
9. Administering Sacred Nursing Acts of Caring-Healing by Tending to Basic Human Needs
10. Opening and Attending to Spiritual/Mysterious and Existential Unknowns of Life-Death (Watson, 2008)

The concepts of intentionality and consciousness became core concepts of transpersonal nursing. Caring-healing modalities were incorporated into the theory. Her term "Caritas Consciousness" is congruent with Newman's unitary transformative paradigm and Rogers' Unitary Science in

that caring and love call upon higher levels of consciousness and “make connections between caring and healing/health/wholeness outcomes, transcending conventional outcomes of curing alone” (Watson, 2008, p. 70). She described her transpersonal caring relationship which is guided by an evolving Caritas Consciousness. “It conveys a concern for the inner life world and subjective meaning of another; that other is fully embodied, that is, embodied spirit” (Watson, 2008, p. 79). The Caring Moments occur when a nurse is fully present in the moment and seeks “to see” who the patient is using all their skill, knowledge and resources and ways of knowing. This connection in the now transcends space and time and has a field greater than those who experience it (Watson, 2008, p. 82). One characteristic of the theory is that it is reciprocal and holographic as evident from the following premises which Watson described in 2005:

- The totality of Caritas Consciousness is contained and communicated in a single caring moment
- The one caring and the one-being-cared-for are connected with each other and the unified field of the universe to which we all belong
- *Caritas Consciousness* of the nurse is communicated to the other
- *Caritas Consciousness* transcends the moment; thus it has possibilities that affect both people beyond the moment (Watson, 2008, p. 82)

Watson stated “The holographic view of caring mirrors the holographic universe: that is, the whole is in each part, and each part affects the whole” (2008, p. 10). She retitled her theory Human Caring Science, as her own thinking evolved and because “once one places the human and caring and even concepts of love and healing into a model of science, we have to acknowledge we have a different model of science that emerges from disciplinary maturity” (2012, p. xi). This demonstrates how she considers her theory a work in progress, ever evolving—as we are.

In 2002 Sitzman judged the concepts of the core and trim were no longer discrete but part of a whole and the concept of interbeing became a powerful tool for understanding and applying

the theory. She explains that Thich Naht Hanh's term *interbeing* describes the intersecting and merging of ideas such as core and trim; it acknowledges that all existence is interdependent and interconnected. Because his concept of interbeing strongly resembles Watson's theory, she proposes that mindfulness techniques could provide the preparation nurses need to appreciate and work within the holistic paradigm of mind, body, and spirit, and understand the theory of human caring.

Despite some critiques of caring theories, Bailey (2009) reports an increased focus on caring and caring knowledge development in the past two to three decades, and additionally that scholars outside of nursing in the disciplines of theology, education, ecology, and ethics add to the importance of this concept in research and application. Some critics of Watson's theory cite the changing title of the theory and terms (Wehr, 2018). While the change is potentially confusing when trying to learn the complex theory, she has rationale for the changes, which are defended as evolutionary. The question of its relationship to evidence-based practice has been raised and is answered by Fawcett et al. (2001) who argue that each pattern of knowing, such as empirics, ethics, personal, and aesthetics as defined by Carper in 1978 can be considered a type of theory and different form of inquiry used to yield different types of evidence, all of which are needed for evidence-based practice, not empirical knowledge alone. They claim nursing has largely ignored this disciplinary perspective and reverted to a medical perspective of evidence when discussing evidence-based nursing practice. They prefer the term "theory-guided, evidence based practice." Watson states "The use of scientific problem solving remains the structure for nursing but goes beyond a limited interpretation of knowledge and method, honoring unknown subjective phenomena, theories, and conceptual problems as well as scientific

data” (2008, p. 116). She also credits personal knowledge with promoting wholeness and integrity in the personal encounter and achievement of engagement rather than detachment.

Studies Linking Watson’s Theory and Pain

Watson & Foster (2003) stated “Caring theory and pain theory are congruent in their contemporary focus on the subjective human experience, the inner life processes, and meaning of the experience” (p. 364). They proposed a model called The Attending Nurse Caring Model in which they integrated theory, evidence, and advanced caring-healing therapeutics for transforming professional practice relating to children’s pain. The study was piloted in a children’s hospital and is both discipline-specific and trans-disciplinary using a hospitalist advanced practice nurse concept. In the pilot, participants initiated the search for the evidence, as they define clinical problems in pain management. Reflective activities and nurses’ writing nursing directions for comfort measures and relaxation on the order sheet in medical record were reported. They reported that this addressed the dissonance between nursing theory and practice and offers hope for transforming both nurse and system. It has served as a model for other units in the hospital and additional projects were underway in hospitals throughout the country, many of which were Magnet designated, or applying for Magnet status using the caring theory ethic as the underlying professional practice model.

Carpenter et al. (2016) performed an integrative review informed by Watson’s theory as a guiding framework. Based on evidence from 22 studies, they recommended that guided imagery may be used as an adjunct for pain management in patients undergoing surgery. This holistic modality assists clients in connecting with inner knowledge at the thinking, feeling, and sensing levels, promoting innate healing abilities. Together nurse and client co-created an effective way to work with pain.

Quinlan-Colwell (2010) explored the paradoxical relationship between patient satisfaction and patient-reported pain scores and concluded that “caring holistic nurse manifest transpersonal connections through which patients paradoxically are satisfied even when pain is not eliminated (p. 181). This emphasizes the importance of the caring by the nurse to the patient.

Smith et al. (2002) examined the effect of therapeutic massage on perception of pain, subjective sleep quality, symptom distress, and anxiety in patients hospitalized for treatment of cancer. In therapeutic massage the caring intentions manifest as field vibrations of higher frequencies and this higher frequency pattern resonates with the recipient’s field, entraining toward field integrity and harmony. Statistically significant interactions were found for pain, symptom distress, and sleep. Sleep improved only slightly for the massage group, but deteriorated significantly for those in the control group. Findings support the potential for massage as a nursing therapeutic for cancer patients receiving chemotherapy or radiation therapy.

Dorsey et al. (2001) explored differences in perceptions of nurses’ caring behaviors between adults with sickle cell disease and general medical conditions and between female and male patients with sickle cell disease. Participants with sickle cell disease and women with sickle cell disease reported lower satisfaction with nurses’ behaviors. The authors noted that while Watson’s theory provides an excellent philosophy for nursing care, its abstractness makes it difficult as a tool to guide nursing research.

Gillespie et al. (2012) examined nurse caring behaviors identified as important to parents of pediatric patients in a pediatric emergency department. Leading the behaviors identified as most important centered on carative factors of “human needs assistance” and “sensitivity to self and others.” A pilot quasi-experimental study by Broschious et al. (2015) was done at an acute

care hospital's rehabilitation unit to determine the effect of a three-minute slow back massage during evening nursing care on patient perceptions of nurse caring. There was no statistically significant difference between the intervention and control groups on patient perception of nurse caring; this was an unexpected finding. But there was a strong, non-statistically significant relationship between nursing care behaviors and pain ratings post-bedtime nursing care. In the discussion it was mentioned the control group may have seen even the routine evening care as a caring endeavor. This author wonders if perhaps this actually supports Watson's theory since routine nursing care was viewed as caring.

Some studies have supported the use of Watson's theory in nursing education. Costello & Barron (2017) incorporated it as the framework for an end of life course for senior nursing students as a meaning of teaching compassionate care. The students were introduced to the theory and the Caritas Processes, concepts of caring moments, and multiple ways of knowing. The outcome was that students reported they felt more aware of how to provide compassionate care to their patients at this stage of life.

Sitzman (2007) created a course for senior BSN students focused on Jean Watson's definition of caring and based on a deepened understanding of this sometimes misunderstood and trivialized term. "Students often verbalized the realization that the transpersonal deep caring is not necessarily expressed in obvious, outward displays but is subtly, holistically conveyed as a result of an inward stance assumed by the one providing care" (p. 15).

Rossillo (2018) found a significant improvement in caring efficacy in new graduate nurses immediately after an educational intervention consisting of experiential learning activities, and the improvement was sustained six to nine months later. Additionally, engaging

and developing self-care in newly graduated nurses early in their career may improve resiliency and decrease burnout.

Quinn et al. (2003) noted that there is a wealth of qualitative data suggesting the importance of the healing relationship, as defined in the literature on caring within the discipline of nursing and a dearth of outcomes studies to support these qualitative findings. They proposed guidelines for research methodologies to elucidate both the process and outcomes of healing relationships in clinical nursing practice. Kramer et al. (2014) noted process measurement is integral to understanding and improvement of nursing practices and engage in gap analysis and strategic improvement to professional nursing practices as well as patient and practitioner outcomes. Four items were selected in their study as “very important” by nurses: the core value of concern for the patient, compassionate caring, compassionate patient environment, and clinically competent peers.

In 2015 Watson & Brewer reported spending four years developing caring indicators that extend beyond conventional problem-focused nursing to validate new forms of authentic caring science scholarship representative of the finest of health-care reform. They also explained that the Watson Caritas Patient Survey (WCPS), a five-item instrument designed to capture patient perceptions of caring practices of their caregivers, a critical indicator of personal human-to-human connection, is being used in multisite clinical research. This research was in hospital systems using Watson’s Theory of Human Caring and Caring Science as a theoretical framework for advancing professional practice. Watson (2015) reported that Watson Caring Science Institute (WCSI) has been identifying care indicators that extend beyond conventional problem-focused nursing sensitive outcomes data to validate new forms of authentic caring science practices and scholarship. An International Watson Caritas Comparative Database was also

established to measure outcomes of caring as defined by the theory. A computerized clinical documentation system was devised by a hospital system to provide a common language for nurses to document patient experiences, nursing diagnoses, nursing interventions, and outcomes using standardized language specific to the theory (Watson, 2008). This is important because her theory attempts to find and deepen language specific to nurse caring relationship since what nurses do will not be recognized if it is not documented.

The emergence of the digital age has expanded the role of the nurse beyond face-to-face into the realm of cyberspace. Caring can occur via disembodied human-to-human connections (Sitzman, 2007). Ten studies were cited by Sitzman (2017) based on Watson's human caring theory, all with a focus on teaching, conveying, and sustaining caring in online nursing classrooms. She concluded that effective integration of a theoretical framework is a hallmark of universality and elemental resonance, adding that "Watson's work transcends time, space, and proximity, allowing it to serve as an effective framework for exploration and discovery now and into the future as new ways of interacting, connecting, loving, and caring unfold" (p. 50). Her theory continues to inform research, patient care, nursing education and the profession. She challenges nurses to continue to transform health care by living her theory. Ray & Turkel (2014) call on nurses "to realize the full potential that the power of caring has on patient and organizational outcomes" (p. 132).

Relevance of The Theory of Human Caring to Setting

Watson's theory can deliver what patients with chronic pain need. Where a specific Caritas Process can meet the patient's need it will be mentioned here. The evidence suggests health care professionals may be able to interrupt the downward spiral for the patient with persistent pain by intervening early at the point when acute pain becomes chronic. Based on the

neuroplasticity described by Thorn (2004), “It is not out of the realm of possibilities that adaptive cognitive and emotional processes could produce reparative modifications of the nervous system” (p. 237). Attention should be directed toward promoting adaptive cognitive and emotional processes as early as possible on the continuum where pain transitions from acute to chronic, as this may represent a critical time for support and guidance—a point at which intervention by the nurse may be preventative as well as protective. This is a time of vulnerability, and based on Watson’s theory it represents a time when the transpersonal caring relationship can help to promote healing. It also incorporates chaos theory, which would identify the patient as in a state of disequilibrium, at the bifurcation point, and the nurse’s presence has an influence as both an external condition and an exchange source of energy, information, and material. The enactment of transpersonal caring-healing modalities may “influence the patient’s progression at the chaotic bifurcation point of illness, disease, and suffering” (Clark, 2003, p. 35). She further explains that much of what the nurse does at that point is enacted by creating and holding a positive intentionality for the patient (Clark, 2003). Quinn et al, 2003, add “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” (p. A69).

Also important is the observation that a shift from beliefs about helplessness and passivity to resourcefulness and ability to function, regardless of pain, accompanies successful rehabilitation (Turk & Monarch, in Turk & Gatchel, 2002). The role of self-efficacy is relevant here. According to the Social Learning Theory of Bandura (1977), “The strength of people’s convictions in their own effectiveness determines whether they will even try to cope with difficult situations,” and “efficacy expectancy determines how much effort people will expend

and how long they will persist in the face of obstacles and aversive experiences” (p. 79-80). If nurses can connect through transpersonal caring they will better understand what the patient is experiencing and recognize the extent of the patient’s self-efficacy and their usual ways of coping, and their effectiveness, when confronted with their reality of chronic pain.

The degree to which spiritual beliefs and practices affect the patient’s life needs to be assessed. Many people seek solace and inspiration through their spirituality. Plus, the redemptive nature of suffering is a theme in many world religions, and especially in the Judeo-Christian tradition. Watson advises us to

look at and into the inner-life world through the other person’s eyes, not through a medical lens. For it is only through a broader, more existential-spiritual lens that we can surrender to the mysteries of human life and human predicaments. (2008, p. 192)

Describing the importance of Caritas #10, Watson states “We open our hearts and minds to seek a deeper, more intimate relationship with that which is greater than self, the Divine” (2008, p. 194). Further, “Acknowledging and incorporating this Caritas Process into nurses’ understanding of practice can be a guiding influence and a turning point for healing, whereby a tragedy can turn into a miracle of courage and strength, opening to another reality of life’s deep meaning” (Watson, 2008, p. 193). If nurses are able to connect with a patient’s sense of spirituality they will be able to support the patient in becoming more evolved spiritually. The meaning of their pain will affect how it is dealt with. As Caudill (2016) reminds us, along with the biological meaning of pain (as a signal the body has been harmed), additional meanings include psychological, behavioral, spiritual, cultural, and cognitive. She notes a person thinks about its meaning, cause, and possible remedies. She uses childbirth to illustrate that the situation in which pain occurs may modify the emotions and response to pain. Ferrell & Neff (2008) observe “Pain that persists without meaning becomes suffering”

(p. 247). According to Lazarus & Folkman (1984) existential beliefs enable people to create meaning and maintain hope in difficult circumstances, but they are not sufficient to explain appraisal; rather, commitments and beliefs work interdependently with situational factors to determine the extent to which harm/loss, threat, or challenge will be experienced (p. 80-81). This underscores the importance of listening to understand what the patient is thinking and feeling. Listening is an important part of being authentically present, which is Caritas #2. Maladaptive modes of thought arise from a faulty premise on which an appraisal or conclusion is built, or from faulty reasoning due to emotional interference (Lazarus & Folkman, 1984, p. 341). Consider that one can deal with most anything for a moment; it's different when the situation continues from moment to moment with no respite. Learning how to deal with pain in the moment can help the patient cope with pain. While "it may seem counterintuitive, meditating into pain as opposed to trying to distract from it can be beneficial to people in pain" . . . "Focusing on pain, but not judging it, can help patients feel more in control and live in the now," and "Over time patients are able to actually almost embrace their pain with a sense of kindness" (Fargo, 2018, para. 1). In this way, the patient can learn to control their pain instead of the pain controlling the patient. This is important. Teaching mindfulness techniques, which is an intervention Watson embraces, should be encouraged and taught by nurses experienced with the techniques. Each patient may need a different combination of modalities tailored to individual need. Of interest, Barrie notes "Empowering patients to self-manage their chronic pain can lead to improved person-centered outcomes" (2011, p. 38). Additional authors concur, citing the importance of patient engagement (Lee, 2010; Pain Medicine, 2005; IOM, 2011; IPRCC, 2016). Evidence supports that it may well be *the person himself/herself* that is best suited to manage their chronic pain; however, they

need nursing support to navigate the maze of information and misinformation, to overcome barriers, and to locate the right resources and combination of management strategies for them. Goals need to be mutually set and agreed upon by the patient, physician and nurse. They should be related not only to pain relief, but also function and quality of life and life satisfaction. It is particularly important that the goals be realistic, especially as regards pain relief, since total relief may not be possible. Therefore, the nurse should strive to relieve the pain to the extent possible and help the patient cope with the pain which remains. Watson's transpersonal theory is such an approach. It is holistic and interdisciplinary and striving is emphasized for both patient and nurse. The nurse works to empower the patient to function at their highest possible level.

This use of Caritas #1, showing loving kindness to the patient, may be the most important thing the nurse does to help the person in pain. It is essential to forming the biogenic or healing relationship. Caritas #6 describes how the nurse uses self as part of the caring process to engage in the artistry of helping the patient problem-solve for ways to try to decrease their pain and increase their function, exploring all modalities, even those which may seem foreign. The nurse's assistance with problem-solving affords the patient opportunities they may not have considered for pain relief, for example relaxation techniques and learning to work with the pain. Caritas #7 involves the nurse assuming more of a coaching role when teaching techniques that may be helpful to mitigate the pain.

Compassionate Care Needed

In addition to the patients in pain presenting a challenge, chronic pain taxes the significant others as well, along with the health care providers. Patients are often not at their best and may be irritable and angry, presenting a challenge to health care providers. A recent

study done by Henry (2017) found substantial divergence in pain treatment goals of the patient versus the goals of the physician. “While patients prioritize a reduction in pain intensity and, secondarily, an understanding of the cause of their pain, clinicians place greater emphasis on improving physical function and reducing or avoiding side effects from medication, including risk of dependency” (para. 1). Patients really want their pain eliminated, but not all pain can be eliminated; for some people it will be intractable. “Regardless of what you DO an estimated 5-10% will be refractory to the majority of modalities” (Pain Medicine, 2005, S1, p. 14).

However, it can be treated, lessened and managed by learning to accept and cope (Cederberg et al., 2016). One needs to control the pain, instead of the other way around. Chronic pain can be transcended on a personal level *by the patient*, with support from healthcare professionals and society. The need for compassionate care was rated as “very important” to successful medical treatment by patients and physicians alike. “However, only 53% of patients and 58% of physicians said that the health care system generally provides compassionate care” (Lown et al., 2011, p. 1772). These authors noted a positive correlation between communication, empathy, and compassion with patient and family satisfaction and positive health outcomes, and even lower costs. The relationship the nurse establishes initially with the patient and maintains throughout repeat encounters is central to supporting the patient with pain. The emphasis needs to be on communication, empathy, and compassion. Patients want to know the nurses care and are trying to help. Indeed, nurses have an ethical obligation as part of their professional standard as described in the American Nurses Association’s Code of Ethics (2001) to “practice with compassion and respect.”

Compassionate care is needed for improved patient outcomes when there is chronic pain. Less suffering would be expected to occur in a culture which emphasizes care, which is key to

patient-centered and culturally sensitive care. The patient needs to be assisted with coping and self-management, which is secondary prevention. This fulfills AACN Essential VII: Clinical Prevention and Population Health for the Nation's Health.

Gilbert (2005) explains compassion is not only a process that underpins the building of prosocial relationships with others, but also has great potential to heal our minds and bodies. In Buddhist traditions, compassion is linked to *metta* or loving-kindness, "desire" . . . and further,

Compassion (which is an element of loving-kindness) involves being open to the suffering of self and others, in a non-defensive and non-judgmental way. Compassion also involves a desire to relieve suffering, cognitions related to understanding the causes of suffering, and behaviours—acting with compassion. Hence, it is from a combination of motives, emotions, thoughts and behaviours that compassion emerges. (p. 1)

The Schwartz Center for compassionate care identifies these four essential characteristics of compassionate care:

- 1) Empathy, emotional support, and a desire to relieve a patient's distress and suffering,
- 2) Effective communication at all stages of a patient's illness and treatment,
- 3) Respecting patients' and families' desires to participate in making health care decisions, and
- 4) Knowing and relating to the patient as a whole person, not just a disease. (Lown, 2011)

The Carrier Clinic of New Jersey advertises that the science of compassionate care is incorporated in its mission and vision and a Compassionate Care Index is used, in line with the Patient-Centered Outcomes Research Institute (PCORI) to measure outcomes of care. They explain compassion lies at the intersection of empathy (understanding patient's concerns) and sympathy (feeling patient's emotions); the combination is a response to the distress of others (Parker, 2015). The Compassionate Care Index includes measures of informed shared decision-making, continuity of care, trust, coordination of care across settings and attention to patient preferences. New health care payment systems, including the Centers for Medicare & Medicaid Services' proposed Value Based Program (VBP) system, reward providers for Compassionate

Care. So, aside from the compelling moral and ethical reasons to provide compassionate care, it seems likely this will be a parameter assessed in the future by payers. Burnell & Agan (2013) state, "Compassion has not been universally defined or understood, nonetheless is recognized as a component of nursing excellence" (p. 180). They feel nursing behaviors and actions that exemplify compassion ought to be easily identifiable to patients, and they describe the four categories: the ability to establish meaningful connections, meet expectations, exhibit caring attributes, and function as a capable practitioner. They conclude "compassion may be nursing's most precious asset; however, without a standard definition of its elements and a measurement scale, it cannot be recognized, quantified, or monitored for effectiveness" (2013, p. 186).

Nurses and Pain

Knowledge deficits and lack of confidence in treating chronic pain were cited by physicians (Cayea et al., 2006). If there are barriers for physicians there are likely barriers for nurses as well. Limited nursing research articles were found in the U.S. regarding nurses' knowledge and attitudes toward pain. Of the 22 predominantly international studies identified, most dealt with acute pain, palliative care or end-of-life care, not other non-malignant chronic pain. The Interagency Pain Research Coordinating Committee (IPRCC) report titled National Pain Strategy in 2016 said health care providers "are not adequately prepared and require greater knowledge and skills to contribute to the cultural transformation in the perception and treatment of people with pain" (p. 41). It also noted "Core competencies in pain care are not fully developed and generally do not inform (pre-licensure) curricula" (IPRCC, 2016). There are no competencies for chronic pain on the NCLEX exam for licensure as a Registered Nurse (RN).

The relevant studies in the U.S. included McCaffery & Ferrell (1997), pioneers in palliative care, who reviewed surveys of nurses' knowledge of pain assessment, opioid dosing,

and likelihood of addiction. They found knowledge deficits and assert that responsibility for pain assessment and use of analgesics must be instilled early in the education of nurses. Shaw et al. (2010) found a substantial proportion of the students held misconceptions, but these were held to a lesser degree by the end of their course of study, indicating the need to address these misconceptions in curriculum. Brant et al. (2017) noted “Pain is a nursing sensitive indicator and yet pain is often not well managed in both hospital and ambulatory settings. Improving nurse knowledge and attitudes about pain may translate to improved patient outcomes” (p. 214). From their systematic review of nursing education for managing acute pain in hospital settings Drake et al. (2007) suggested improving pain management requires more than knowledge acquisition; and more recently Drake et al. (2017) state

Barriers to optimal pain management in nursing require further investigation, ensuring that social and professional context, emotional impact, the meaning of the required tasks for nurses and their day-to-day working conditions are addressed by pain management interventions, rather than only information and skills. (p. 14)

The above should be considered when planning to improve the quality of care nurses provide to patients in chronic pain. The affective domain needs to be addressed as well as the cognitive.

Nurses and Self-Compassion

Providing the compassionate care needed by the patient starts with self. “Self-compassion—treating oneself with kindness, care, and concern in the face of negative life events may promote successful self-regulation of health-related behaviors,” according to Terry & Leary (2011, p. 352). They claim it can lower defensiveness, reducing emotional states and self-blame and enabling better coping with stressful events. Further, framing medical problems and their treatment in ways that foster self-compassion may enhance people’s ability to manage their health-related behavior and deal with medical problems. Neff (2003) explains that while in the West compassion is usually understood to relate to compassion for others, in Buddhist

psychology it is as essential to feel compassion for oneself as it is to feel compassion for others. She notes a compassionate stance toward oneself is equilibrated with the mental perspective of mindfulness, which is a nonjudgmental, receptive mind state in which individuals observe their thoughts and feelings as they arise without trying to change them or push them away, but without running away with them either. She found that self-compassion transforms negative self-affect into a more positive affective state, that of kindness and compassion, and proposes its use as a mental health intervention. Neff et al. (2007) report

Self-compassion entails being kind and understanding toward oneself in instances of pain or failure rather than being harshly self-critical; perceiving one's experiences as part of the larger human experience rather than seeing them as isolating; and holding painful thoughts and feelings in mindful awareness rather than over-identifying with them. (p. 139)

Self-compassion was found in their studies to buffer against anxiety when faced with an ego-threat in a laboratory setting. The importance of self-compassion for nurses cannot be overstated. The very connection between nurse and patient can place the nurse at risk for compassion fatigue. Compassion fatigue arises from a rescue-caretaking response, and burnout arises from an assertiveness-goal achievement response (Valent, 2002, in Wu et al., 2016). While different in cause, burnout leads to compassion fatigue, which involves desensitization toward patients and subsequent loss of a nurse's ability to nurture or care adequately for patients (Henson, 2017). "Caring and compassion, which provide nurses with satisfaction and fulfillment in patient care, can contribute to the exhaustion of those emotions and lead to compassion fatigue" (Henson, 2017, p. 139). She proposes "Interventions to support healthy work environments and development of nurses' self-coping skills may help maintain compassion and caring as well as promote well-being" (p. 141). Studies of compassion fatigue and burnout in nurses concur that strategies for self-care and increased support and teamwork in the workplace

are needed (Kehoe, 2006; Wu et al., 2016). Mindfulness and acceptance and commitment training were recommended to improve personal resilience and enable staff to better manage the challenges of modern healthcare in the U.K. (Clift, 2015). Nurses there said that listening to the patient is at the core of compassionate care, but noted the importance of being compassionate to themselves, as this can enhance their compassion for others. The importance of the mutual support of colleagues was noted.

Over the last several decades mindfulness-based interventions have gained wide recognition for difficult to treat clinical problems such as chronic pain, mood disorders, and others, as well as for stress in healthy populations. In health care providers, mindfulness training reduced burnout, mood disturbance and stress. Reducing behavior which places one at risk can help reduce chronic conditions, thus creating a healthier workforce. Some other potential benefits include increased productivity, memory, creativity, focus, impulse control, and emotional intelligence (Kachan et al., 2017). Crane & Ward (2016) report

Today, nurses experience increased stress as a result of more work hours and greater patient loads. Research studies demonstrate the value to an organization and to individuals of educating nurses about self-care. Studies also show that how being aware of individual reaction patterns is vital to learning more effective coping mechanisms. Most self-care skills can be learned and implemented in a short period of time. Nurses are encouraged to experiment with the various techniques to determine the most effective ones for them. (p. 387)

They further note “The conscious leader understands that encouraging nurses to rededicate efforts to their self-care and self-healing is a wise choice to help ensure healthy, more satisfied nurses” (Crane & Ward, 2016, p. 388). These same authors created a continuing education module on self-healing and self-care for nurses and assert that the cost of the tools of emotional self-care and self-healing are low, but can significantly affect the work environment and offer suggestions for creating a healing environment with a dedicated space to reduce stress, and allow

for debriefing and de-escalating. Ultimately, the responsibility for self-care rests with the nurse, but this needs to be supported by the nurse leader who encourages each nurse to spend time observing how he or she responds to challenges and stress in the workplace. A self-inventory is proposed for use when the nurse is in a situation which is upsetting or feels challenging. It should be completed as close to the event as is possible and done mentally or recorded in a journal. This can help increase awareness of reactions and patterns of response. It can then be evaluated to determine if the responses were helpful or need to change. This creates a mechanism for self-awareness and growth. They also encourage mindfulness, which is a technique closely related to meditation and is about maintaining an awareness of self. They recommend techniques of Jon Kabat-Zinn (1990), creator of the popular Mindfulness Based Stress Reduction Program (MBSR), who explains “It will take conscious effort on your part to move in a direction of healing and inner peace. This means learning to work with the very stress and pain that is causing you to suffer” (p. 2). His program, book, and exercises have been supported by researchers and clinicians alike as potentially effective for reducing stress and increasing quality of life and self-compassion. By becoming more conscious of the thoughts creating the stress response, one gains the opportunity to change the thoughts and thus change the reaction. Positive self-talk and affirmations are techniques the nurse can use to counteract negative thoughts. Visualization complements such affirmations. Positive psychology, a gratitude journal and humor are also presented as tools for mental self-care. Additionally, the importance of a spiritual connection is discussed and summed in this statement: “Focusing on a spiritual connection allows you to transcend the challenges in daily life and provides perspective” (Crane & Ward, 2016, p. 396).

Clearly, it is important for nurses to be receptive and responsive to their own journey of reflection and renewal, and not view this creative approach to practice as something they must do. Turkel & Ray (2004) assert that as nurses are less vulnerable to exhaustion, stress, and frustration, will be freer to let their creative, caring spirit emerge. They remind us, “Self-care is critical to health and healing . . . if the nurse does not care for self it is impossible to care for others.” Further, “Strength emerges from struggle, which is necessary for growth, development, and healing. As nurses struggle in their wounded state, compassionate caring holds the key to the meaning of suffering within selves and others” (Turkel & Ray, 2004, p. 250).

A systematic search was undertaken by Hunter (2016) of the U.K. to determine the effectiveness of mindfulness training on nurses and midwives. She reports this creates a quiet mental space giving them agency and perspective and leading them to improved caring. “Mindfulness appears to alter the way nurses and midwives operate within a stressful work environment, thereby changing the way the environment is experienced by themselves and, potentially, the people in their care” (Hunter, 2016, p. 918). This is in contrast to task orientation and depersonalization. Challenges to sustaining mindfulness practice were identified as insufficient time and the difficulty of sustaining practice on one’s own (Hunter, 2016). In the U.S., Myers (2017) explains the importance of self-care and well-being for nurses in the perioperative setting. She reported that nurses are often guilty of caring for others at their own expense and that they must first care for self. She notes stress may interfere with the ability to observe, listen attentively, understand, empathize, and connect with and advocate for patients. Further, mindless interviewing and being on “autopilot” when doing habitual tasks, as well as missing subtle cues, has safety implications, whereas mindfulness enhances communication and interaction between nurse and patient.

Theoretical Framework

The call for compassionate, patient-centered care has been repeated numerous times in the literature, and is perhaps summed best by Jean Watson (2012): “A human caring science approach to health care is required for nursing practice now and in the future” (p. 35). The theoretical framework guiding this project is that of Jean Watson’s *Human Caring Science: A Theory of Nursing*, which is summarized above in the Literature Review. There are several reasons: 1) It is particularly well suited to the needs of chronic pain patients who require compassionate care; 2) It is what patients value; 3) It defines the essence of what we, as nurses, do: care for others; 4) It addresses spirituality and helps us see the potential that caring has for helping the patient deal with what is, and also to share what might be, fully utilizing all resources—those within and those without, and thus, it conveys hope, which is desperately needed; and 5) It is both an invitation and an opportunity to interact with ideas and continue to grow in one’s personal and professional life—it is a process. Since Human Caring Theory is not linear, but dynamic, it was difficult to tease out the individual Caritas Processes which are interwoven, but it was necessary to narrow the focus for this project. Therefore, two Caritas Processes, #1 and #6, were chosen to best accomplish project goals. They are discussed further here.

❖ Caritas #1: Embrace Altruistic Values and Practice Loving Kindness With Self and Others

Having a deeply held desire to love and to care, in whatever ways are meaningful and helpful in a given moment, within a given situation, is a starting point. It is a stance, an attitude, an intention, a commitment, and a conscious judgment that manifests itself in concrete acts. It is the core concept which creates openings for the development of unique caring/loving kindness identities. The temperament of the nurse, the temperament of the patient, and other situation-

specific factors will influence what the outward expression of caring loving kindness will be, while the inner resolve of the nurse to *care* and *Love* remains constant. Watson capitalizes Love to denote universal love.

What might this Caritas #1 look like at the Pain Center?

- Staff members will all treat the patient, at all encounters, with transpersonal caring.
- The patient will know there is a caring connection.
- Staff members will be treated with the same transpersonal caring and begin their own journey toward self-loving kindness.

To accomplish this last, the nurses will be started on their own journey of cultivating loving kindness in oneself. In order to care for others, one must first care for oneself. This concept is central. The nurse will learn it is necessary to allow oneself to think one's own thoughts and feel one's own feelings. The primary way to develop sensitivity and a need for spiritual practices is to pay attention to our feelings and thoughts—painful as well as happy ones. Then we can empty out, releasing, passing feelings that were contributing to confusion, fear, anger, and so on (Watson, 2008, p. 68). She says the nurse needs to find ways to cultivate a consciousness of Caritas—loving kindness and equanimity—if one is to authentically practice within this paradigm (Watson, 2008, p. 56). This is the meaning of the term Caritas Consciousness.

Considering the experience of patients with chronic pain, being cared for in this manner by a nurse with a Caritas Consciousness can be expected to fulfill their needs on a deep personal level through the development of an authentic trusting, caring relationship. “It is through being present to and allowing constructive expression of all feelings that we create a foundation for trust and caring” (p. 102). Watson calls it transpersonal human caring, and in the caring moment

the nurse enters into the experience of another person and another can enter into the nurse's experience. This is a choice the nurse and patient make. If the patient allows the nurse to enter into their own experience it can release inner power and strength and help the person gain a sense of inner harmony. The transpersonal caring moment is the vehicle for healing; the connection of shared experience. To understand this one needs to consider that the patient had a causal past, lives in the present and has a potential future and so does the nurse; a different one. The nurse partners with the patient, and actually becomes the environment for the patient by entering into the patient's present experience, the energy field called the phenomenal field. This creates vibration in the phenomenal field, which becomes Watson's Caritas field. "This contact and process, in turn, generates and potentiates self-healing properties" (Watson, 2012, p. 71). Further, "We may become the hope for someone who is isolated, alone, abandoned in the prison of his or her despair and illness, fear and suffering" (Watson, 2008, p. 62). It is in this way the nurse can affect the patient, by blending the science with the art of nursing in the care, not merely acting as technicians (Clark, 2003). From a meta-analysis by Swanson in 1999 (as cited by Watson, 2008) the patients who experienced caring had outcomes which included emotional and spiritual well-being, dignity, self-control, and personhood, while consequences of non-caring included feelings of humiliation, fear, feeling out of control, desperate, helpless, alienated, and vulnerable. Interestingly, the same feelings were mirrored in the nurses (p. 74). The relationship is reciprocal. Willerding (2004) notes Watson's theory stresses the importance of the lived experience of the nurse as well as the client, and the way a nurse manages the client's pain is also influenced by her own experience. When a nurse and client come together in a caring moment that incident becomes a unique experience and becomes a part of her or his life history; they are changed. When there is disharmony because of pain, it causes stress and health changes in a

person. The nurse can impact the patient at such times. “To gain a higher degree of harmony within the mind, body and soul is the goal of nursing in a transpersonal caring relationship” (Willerding, 2004, p. 4).

❖ *Caritas #6: Creative Use of Self and All Ways of Knowing as Part of the Caring Process; Engage in the Artistry of Caritas Nursing*

Watson invites us to reconsider the emphasis on evidence-based practice by discussing the types of evidence and the need to not be limited by linear thinking. While “conventional science is thought to be value-neutral; Caring Science is value-laden, philosophically grounded in values of relationship, context, meaning, and subjective view of reality—acknowledging, but not limited to, empirical-objective physical phenomena alone” (Watson, 2008, p. 115). She explains “in a mature model for incorporating evidence, empirical-technical-scientific knowledge and informed moral practice come together in a given moment, drawing upon all of one’s knowledge, experiences, judgment, wisdom, and skills in that moment” (p. 113). “A wise Caritas practitioner seeks to integrate necessary ‘evidence’ at multiple levels with the wise clinical judgment necessary for addressing individual people with individual life stories and circumstances; integrating practitioner and person-patient-family” (p. 112).

Patients with chronic pain may not be aware of the vast array of modalities available to treat their pain and may be overwhelmed by them if they do. Importantly, they have no way to know what may actually work for them. Just as there is wide variation in the way pain is perceived, there is considerable individual variation in pain relief. Plus, the evidence supporting the effectiveness of most modalities is not strong. An important role of the nurse is to help the patient recognize the choices available and match modality with type of pain experience. Many local comfort measures such as application of cold or heat have the advantage of affordability

and are easy to use on their own, while others are quite costly, require a large investment of time, and often are not covered by third-party payers. Many patients do not have the financial resources to try various modalities which are not covered. The nurse can help simplify the options by knowing how the modality is believed to work, as well as the demonstrated evidence of effectiveness for the patient's presenting problem. This will help determine goodness of fit. Accessibility, as well as the patient's preference, culture and belief system are additional considerations when determining the feasibility of a modality. While the field of integrative medicine is growing more popular, to many patients it may seem foreign. By explaining the ancient approaches which have been rediscovered as contributing to healing and wholeness, the nurse can bring the wisdom of the ages to light for patient consideration. Many approaches build upon, extend, and transcend conventional allopathic medicine and at some level draw upon and reinforce the deep belief system of the one being cared for (Watson, 2008, p. 65).

While the traditional pharmacologic and interventional therapies are often helpful in remediating chronic pain, the relief may be temporary and insufficient, and the pain may be intractable. Thus, the patient tries to deal with life and pain simultaneously, meeting with variable levels of success, while searching for solutions. Nurses can help, but as Corsio (2018) notes, "In reality, being authentic/genuine, having unconditional positive regard, and expressing empathy are necessary and sufficient conditions in a therapeutic relationship that are required for change to take place" (para. 1). Patients attempt to cope in their own way, which may be adaptive or maladaptive. It is helpful to consider that "suffering is not synonymous with pain, but is closely associated with it. Physical pain is closely related to psychologic, social, and spiritual distress. Pain that persists without meaning becomes suffering. Nurses play a fundamental role in caring for those who suffer. The relief of suffering is at the core of nurses'

work as a profession committed to human response to illness or injury” (Ferrell & Neff, 2008, p. 246). Patients may lack knowledge regarding what intervention may actually work for them. Nurses practice from their own vantage point to problem solve *with* the patient, using all available evidence and wisdom. The nurse assists the patient to recognize novel ways for dealing with their pain, utilizing available modalities, complementary and integrative. Such intervention is supported by chaos theory, as explained by Clark (2003), while referring to what occurs at the bifurcation points experienced by the patient secondary to instability or disease which can induce regression or new order:

The totality and interconnectedness of human energy fields aligns closely with Watson’s (2000) clinical caritas in that the caring-healing modalities within the milieu of transpersonal caring/caritas consciousness help to potentiate harmony, wholeness, and unity of being. By discharging some of the disharmony and the blocked energy that interferes with the natural healing processes, the nurse may help an other through this process to access the healer within and on some level facilitate the evolutionary process. (p. 37)

She cautions, “However the nurse must be actively practicing self-care and self-love techniques that enable him/her to be present in the caring moment and to live the requisite caring intentionality necessary for fostering patients’ evolutionary processes” (Clark, 2003, p. 37). She believes, “ If the nurse strives to continually hold a caring consciousness, each and every act serves to influence the patients’ healing process” (Clark, 2003, p. 37). She implores nurses to take control over the recreation of our practices to decide how we want to practice—merely as technicians or from a stance of transpersonal interactionism. When the nurse embodies Caritas #1 and Caritas #6 in the care of the patient with chronic pain, this author believes it is the epitome of care and facilitates patient coping. Based on Caritas #6, the following is proposed for nurses practicing at a pain center:

- All nurses will practice from their own vantage point to problem solve with the patient, using all available evidence and wisdom.
- Assist the patient to recognize novel ways to deal with their pain, utilizing all available modalities, complementary/integrative.

III. PROJECT METHODOLOGY

a. Anticipated approval

In the practice setting, approval by the Chief Nursing Office and the Nurse Research Council was required. The project proposal was reviewed and subsequently approved by the CNO and the Nurse Research Council after an Expedited IRB approval was obtained. The CNO agreed to support completion of this project and contact was maintained via email.

b. Phases of the project

Phase I: Obtaining support from stakeholders

Administration was highly supportive of the project. The outpatient supervisor was most supportive of this effort, and of the need for mindfulness in particular. She volunteered that she once converted a bathroom into a centering room. Her direction was sought in selecting another Caritas to implement in addition to Caritas #1 for this project. She indicated agreement with Caritas #6. All nurse administrators agreed to the plan. A separate meeting was scheduled with the nurse-manager for a needs assessment, which is described below, and discussion of the direction of the project in her unit, the Pain Center. Last, but certainly not least, were the staff nurses who would be met at Session 1, recognizing that their support would be vital to the success of the project.

Phase II: Needs assessment

A meeting was arranged with the nurse-manager at the Pain Center. Neither patients nor nurses were present but the facility was toured to learn as much as possible about the outpatient unit, referred to as the Center. Questions were answered and their forms and brochures were collected for later use. The staff consists of a secretary, a medical director of the Center, four anesthesiologists who use the Center, and four nurses, two of whom are new to this setting but have experience in the post-anesthesia area. Usually two anesthesiologists and two nurses work at any given time. Approximately 120 patients are seen in the Center per month. The physical environment was assessed and it was noted that there were no patient education posters or literature visible, nor were there works of art or pictures which can be used as a focal point. There was a brochure rack which contained brochures about the Center and about procedures and devices. No mention of complementary or integrative therapies was made. The appearance was clean and neat with an institutional feel.

The nurses chart on a Minor Procedure Nurse Care/Flow Sheet and there is a Patient Questionnaire; upon completion these forms are scanned into the computer. Pain is assessed via the Numeric Rating Scale (Partners Against Pain, n.d.), in which the patient is asked to rate their pain on a scale from 0 to 10, with 10 being the worst pain imaginable. The lack of consistency from person to person and increased sensitivity at the extremes of this scale, as opposed to the middle, have been cited as problematic when assessing pain (Walton, 2018). In addition, it lacks robust measures of pain-related function and quality of life (Morasco et al., 2018). On their institutional Patient Questionnaire there are descriptors which provide perspective for the selected number: How is your pain right now? Your pain at its worst? Your pain at its least? The worst toothache you ever had? The worst stomachache you ever had? Labor pain? The lack of

consistency from person to person has been cited in the literature as problematic when assessing pain, so this represents an attempt to gain context for each patient. There is a question asking if the patient “has ever had anxiety, depression or other condition that was treated by a psychiatrist or psychologist or for which they have been hospitalized.” There is also the question “Do you presently feel depressed?” Another question is “Have you ever had a problem with drugs or alcohol?” The first three questions are on the Minor Procedure Nurses Care/Flow Sheet, as well as the pain goal. There are also three questions the nurse asks: “What makes the pain worse?” “What do you do to relieve the pain?” and “What is the impact of the pain on your activities of daily living?” On the patient questionnaire, there is a question which gets to the degree of impact the pain is having on the patient’s life. It is “List specific ways your life would be different if you had less pain or no pain.” There had been no recent in-service education for the nursing staff on the topic of pain. Most of their patients have health insurance or are private pay. Some patients receive treatment once, and some are regular patients who come for their pain management. A social worker can be called to assist with problems. Counseling is not offered on-site despite the brochures which list biofeedback, counseling, education programs, relaxation techniques, stress management, physical therapy, massage therapy and acupuncture as treatment techniques utilized. The patient is referred for these services by the physician when indicated, and routinely when being considered for a spinal cord stimulator.

Discussions ensued with the nurse-manager regarding scheduling the nursing education since the nurses are not scheduled on the same days. Arrangements were made to schedule a time when all could be available. The project was presented as requiring four sessions, the length of which could be variable, but one needed to be an hour. The tour included visiting what is called the Centering Room. The room is on another floor and is decorated with her own

artifacts, which make it quite Zen, with a few meditating cushions, meditation tapes, and a meditation bowl. The nurse-manager was kept informed of all plans via email and sent four nursing journal articles electronically for the nurses to read in advance of Session 1.

Phase III: Initial implementation

This was a two-pronged intervention, with Session 1 on June 13, 2017, focused on the care of nurses themselves, Caritas #1, and Session 2 on August 16, 2017, focused on Caritas #6. The purpose of Session 1 was to provide the nurses with a special time for themselves. The sample consisted of three staff nurses, the nurse manager and the nurse supervisor of the outpatient services area. The hospital's Centering Room was used and the nurses were greeted and honored. They were offered cold flavored water and the nurse manager brought aromatherapy scents, inviting the nurses to each select their own scent to apply to the wrist or breathe in an atomizer. The focus was on the nurses, taking time out and reflecting on the good that they do and seek in their personal life, the world, and with their patients.

After introductions and anonymity assured, nurses were instructed to complete the *Nurses' Demographic Survey* (Appendix G) which was created by this author. It was completed at the beginning of Session 1 by the participants. The two pre-test surveys (described below) were also given at this time. These are The *Watson Caritas Self-Rating Score* (Appendix H) and the survey self-designed by this author, the *Self-Rating Survey of Caring* (Appendix I). Time was provided to complete the surveys and place them in an envelope. The post-tests of these two surveys was administered after Session 2 and mailed to the author. There is also a *Post-Survey of Nurses* (Appendix J) which was administered after Session 3. The tools are described below.

1. The Watson Caritas Self-Rating Score

This tool is specific to treating self with loving-kindness and practicing self-care and consists of a 5-item scale which was condensed from the 10-item scale used previously but shortened to capture the caring elements in a shorter, simpler questionnaire. It is now titled *Watson Caritas Self-Rating Score* (2012) because it is the version for use by the nurse, not the patient. It is a Likert-type scale with 1 meaning Never and 7 meaning Always. Permission to use the *Watson Caritas Self-Rating Score* (2012) was requested and granted (Appendix K), and purchased from Watson's website. As for the patient version, referenced in the Literature Review, the only information available for the Watson Caritas Patient Score (WCPS) is:

The Watson Caritas Patient Score® (WCPS) is a reliable and valid instrument used in hospitals and systems throughout the United States (and other parts of the world) to assess perspectives of caring practices of hospital staff, of colleagues and peers (with different versions). NOTE: All tools under development, except WCPS®. (Watson Institute homepage, personal communication, February 8, 2018)

Information on statistical measures has not yet been published for the *Watson Caritas Self-Rating Score*, but the reported reliability was Cronbach's alpha of .84. Exploratory factor analysis shows a single factor with loadings ranging from .49 to .73, explaining 61.6% of the variance (Brewer, B., personal communication, February 9, 2018).

2. Self-Rating Survey of Caring

In order to measure the change for Caritas #6, a tool which measured the other Caritas Processes was needed. Since they are intertwined, an improvement in one could be anticipated to improve others. Searching for a tool to measure all the Caritas Processes led to the Caritas Process Factor Survey (CPS) developed by DiNapoli, Nelson, Turkel & Watson (2010). This measures the Caritas Processes from the patients' perception of care received by the nurse. They used exploratory factor analysis to examine the underlying structure of the initial 20-item CPS.

The final factor loadings for one of each of the 10 paired items ranged from .833 to .891. The reliability of the final 10-item CPS using Cronbach's alpha = .89. The factor that accounted for 66% of the variance was factor one, the practice of loving kindness (DiNapoli et al., 2010, p. 17). These same authors state "By examining the underlying structure of the CPS it was discovered that taken together, the caritas processes are a measure of a single entity, which is caring: the unique caring that is central to the discipline of nursing" (p. 18). They further state, "The 10-item CPS can be used by registered nurses in the practice setting to measure caring when practice is guided by Watson's (1979) theory of human caring" (p. 15). However, this tool is for a patient to use to evaluate the behavior of the nurse. A tool for use by the nurse to evaluate personal use of each Caritas Process was desired, but not found. Therefore, one was self-designed for this project, the *Self-Rating Survey of Caring*, by modifying the CPS for the nurse to use for self-evaluation. The wording was changed to reflect the nurses' perception of how well they presently and consistently use human-to-human caring, as defined by Jean Watson. Each of the ten statements was reworded to describe the intention or action of the nurse, which correlates directly with each Caritas; see *Self-Rating Survey of Caring* (Appendix I). It is a Likert-type scale with 1 meaning Never and 7 meaning Always, with numbers in between along a continuum. If unfamiliar with a term, UNK for "unknown" was provided. Since this is a piloting of the tool it has no established validity or reliability. However, it is based on the CPS scale described above which measures the opposite side of the coin for each Caritas. Since it examines the same construct but from a different perspective, it needs to be tested.

3. The Post-Survey of Nurses

This survey (Appendix J) was administered after Session 3 and used to measure nurses' responses to five questions in the cognitive domain and seven in the affective domain. It was

collected directly following the session. Time was provided after introductions to complete the surveys and place them in an envelope before Session 1. Instruction proceeded while seated informally, via a PowerPoint (PPT) presentation providing an overview of the project and of Watson's Human Science Caring Theory, with the rationale that it provides a structure and language for what nurses do. It was explained that the project would focus on Caritas #1 and #6, but for Session 1 guidance would be on Caritas #1 specifically, because of the importance of being in right-relation with self in order to be able to enter the transpersonal caring relationship with patients. The nurse reflects on self and asks, "*What do I need to be?*" Suggestions for ways to achieve Caritas #1 were provided along with additional supplementary materials. They were taught the benefits of self-care in general and mindfulness in particular, and how this relates to Jean Watson's theory of caring. Instruction in both breathing techniques and meditation was provided didactically and experientially with a guided meditation from Jean Watson's audio CD. Setting the intention of awareness through mindfulness was taught; this plus relaxation equals adaptive coping. The attendees seemed to enjoy the meditation, and they viewed one PPT slide which depicts the dynamics of the transpersonal caring relationship (Appendix E) with particular interest. This illustration makes the complex theory understandable and led to further explanation and discussion of transpersonal caring—what it really means to join *with* the patient; to experience *with* him/her. The concept of reflective journaling was introduced.

To support their Caritas Consciousness journey, materials for increased learning and reinforcement of concepts were distributed. This included four nursing journal articles about self-care for nurses. Guidelines were provided for their homework, which consisted of self-awareness, setting personal goals based on a personal assessment, and meditating (or exercise or prayer done with intention) at least six days per week for a minimum of 10 minutes per day for

the next six weeks. They were asked to record their personal assessment and personal goals initially, and then make a reflective journal entry daily. This could be as brief or extensive as desired, and was for their personal use only. Guidelines for reflective journaling were provided. Providing these materials, plus a journal and pen, for their daily homework was intended to help ensure the action desired. Participants also received a set of cards which beautifully contain each of the Caritas principles, along with the gift of a touchstone to keep in one's pocket, which was expected to be motivational as well. On one side of the metal touchstone (1" x 1 ½") was an embossed heart and on the reverse the words "Nursing—a work of the heart." Nurses were encouraged to keep this in their pocket and touch it whenever feeling stressed during the day. This should signal the need for centering as a response to stress. It was recognized that capturing and maintaining the interest of these nurses would be vital to the success of this project. Positive energy was demonstrated; the project was underway. They expressed appreciation for the session, the touchstone, materials and lavender hand sanitizer. It was hoped that the nurses would do their homework and practice mindfulness, daily centering, and reflective journaling during the course of the project. If so, there should be improvement of self-care practices for self; it should gradually become a habit of mind.

Because time constraints reduced the number of sessions from four to two, it was necessary to find an alternate way to maintain contact until Session 2 seven weeks later in order to accomplish project goals. An email group was created as the mode of communication based on the email addresses of the nurses, and weekly messages were sent. This author's name, cell number and email address were attached to their materials. They were advised to make contact with any questions or problems. The day after Session 1 a thank-you message was sent to the email group and instructions were provided for installation of a free app on their phones called

Insight Timer and another called Calm. These were intended to act as handy ways to locate and select a meditation over the ensuing weeks. A return email was requested, but not received in a timely manner, so the nurse-manager's assistance was requested to prompt staff to send email confirmation. It was summer and prime time for vacation, but eventually confirmation was received and each week an additional message was sent with affirmations and suggestions to maintain contact and keep the momentum for project activities.

Phase IV: Ongoing implementation

The first three email messages focused on affirmations of the nurse and served as a gentle reminder. Four weeks into Phase IV, the message shifted from a focus on self to a focus on others. The next week they were asked to consider about how the Caritas principles might be applied to their co-workers at the Pain Center because interconnectedness with co-workers is important for collaboration and provision of holistic care (Sitzman, 2007). The next week, which was one week before Session 2, to stimulate thoughts before meeting, they were asked to consider how the Caritas principles might be applied to their patients. Nurses were ready to become the environment for the patient. At this point, nurses can become attuned to the fact that his/her mood, demeanor, and presence affect the human-environmental field.

During this time, a PPT was used to direct the face-to-face second educational session, which occurred on August 16, and focused on the experience and needs of the patient with chronic pain, and how the nurse can intervene to meet those needs. As there was only one hour, the focus was on the most important aspect: the patient experience and how the nurse can use the Caritas principles to help. The nurse reflects on self: "*What do I need to see?*" Instead of a conference room, the session was held in the Center, around a low table in the nurses' area. The nurses participated in discussion, making comments and asking questions. An electronic copy of

the PPT was sent to the nurse-manager who promised to provide hard copies to the nurses afterward. Many of the slides were included for reference in an attempt to be comprehensive and follow the suggested educational curriculum of the International Association for the Study of Pain (IASP, 2004). Supplementary educational materials and readings were also provided.

A description of Caritas #6 and what it might look like at the Center (Appendix F) was created after Session 2 to reinforce the information presented in the PPT and to be on hand as a reminder. To promote sustainability, this description will be available for future reference and for new hires.

Following the session, the post-test of the *Watson Caritas Self-Rating Score* and the *Self-Rating Survey of Caring* were distributed for completion. The nurse-manager collected and mailed these surveys in the same manner described previously. Post-implementation it was requested that a follow-up third session be held to further explore with the nurses the application of Caritas #6 to the Pain Center in light of the large amount of information presented at Session 2 and lack of time for discussion afterward. Another PPT was prepared and presented in November at Session 3, which summarized the role of the nurse using Caritas #1 and Caritas #6. This provided time for discussion and ideas for future initiatives. A *Post-Survey* to evaluate the overall effectiveness of the entire project was self-designed and completed by the nurses immediately following the session (Appendix J). Packets of fresh lavender were available to provide a relaxing scent and they were given to the staff nurses as a token of appreciation and a reinforcement of promoting self-care.

Phase V: Project evaluation

Evaluation is based on verbal and non-verbal responses during and upon completion of each session and on analysis of the change from pre-test of the surveys, *Watson Caritas Self-*

Rating Score and the *Self-Rating Survey of Caring*, administered before Session 1 and the post-tests of these same surveys after the educational intervention following Session 2, and the *Post-Survey of Nurses* following Session 3.

The demographics of participants assessed by the *Nurses' Demographic Survey*, completed by participants at the beginning of Session 1 indicate the following characteristics: All female, ages ranging from three nurses between 46 and 50, one between 51 and 56, and one between 57 and 60. This was an experienced group of nurses, with two employed as RNs for 7 years, one for 23, and another for 25 years. Basic educational preparation included three with an Associate's Degree (AD) and two with a Bachelor of Science in Nursing (BSN), one with an AD in Nursing, two with a BSN, one nurse with a Bachelors in Community Health, and one with a Master's in Nursing (MSN). Time worked in the Center ranged from 5 months to 9 years. One nurse had overseen the Center for three months, and one nurse did not answer. All five indicated they were aware of the Centering room and have used it, ranging in time from 1-3 for two nurses to over 10 times for one. One nurse indicated never practicing mindfulness, while four did practice: one daily, one two times per week, one four times per week, and one seven times per week. Two nurses indicated practicing meditation on a regular basis (one 5-6 times/week and one 7 times/week) and three did not.

It was anticipated that the content presented at Session 1, plus the content in the supplementary materials provided, would result in improved self-care and more loving kindness of self. The nurses were expected to demonstrate increased knowledge in the cognitive and the affective domain. A positive behavior change was expected regarding self-care and the internalization of Caritas #1, with attendant behavior change to exemplify loving kindness to others, particularly other staff members and their patients. Another goal was for the nurses to be

in better position to enter into transpersonal caring relationships with patients. To evaluate this change, two surveys were used: the *Watson Caritas Self-Rating Score* (Appendix H) and the *Self-Rating Survey of Caring* (Appendix I). Change in a positive direction was expected in these, and positive responses for items on the *Post-Survey of Nurses* (Appendix J).

IV. PROJECT OUTCOMES

The first of the project's short-term goals, that nurses would practice centering ten minutes per day along with reflective journaling six days a week, would be achieved if the nurses did their assigned homework. This was not measured, as they were on the honor system, but there was an expectation that this would be met. The second goal, that nurses would share their thoughts and experiences, was achieved at the end of Sessions 2 and 3. The third short-term goal of creating a healing physical environment cannot be evaluated, but should manifest over time. The behavior of the staff is expected to change in a positive direction, with a display of interest in making the physical environment more attractive and inspiring for the staff and patients alike. The nurses expressed interest in this at the end of Session 2 when ideas for the future were explored and this author presented them with a painting featuring the word "Believe."

The two post-tests were distributed at the end of Session 2 and the nurses were asked to complete the post-tests at their leisure and return to the nurse-manager who mailed them to this author for tabulation.

Results for the *Watson Caritas Self-Rating Score* are shown in Table 1 below.

Table 1

Watson Caritas Self-Rating Score

Caritas Question	Pre-Test (n=5)	Post-Test (n=4)	Change
<i>I treat myself with loving-kindness.</i>			
4 Value	2	0	
5 Value	1	1	
7 Value	2	3	
Average Score	5.4	6.75	+1.35
<i>I practice self care as a means for meeting my own basic needs.</i>			
4 Value	2	0	
5 Value	1	0	
6 Value	0	1	
7 Value	2	3	
Average Score	5.4	6.75	+1.35
<i>I have helping and trusting relationships with others.</i>			
6 Value	2	0	
7 Value	3	4	
Average Score	6.6	7	+0.4
<i>I create a caring environment that helps me flourish.</i>			
5 Value	1	0	
6 Value	2	1	
7 Value	2	3	
Average Score	5.4	6.75	+1.35
<i>I value my own beliefs and faith, allowing for my personal success.</i>			
6 Value	1	0	
7 Value	4	5	
Average Score	6.9	7	+0.1
Total of Average	30.4	34	+ 3.6

From Table 1, the relatively high scores on the pre-test, with an average score of 6.08 for the total of the five questions, indicates these nurses already had an above-average rating of their own caring ability. This might be expected in such a group of nurses who elect to work with pain patients. Subsequent to completion of the instruction and homework activities and after Session 2, there was an increase in the average total score to 6.80, thus a .72 increase in average

score. The total scores all improved and the scores for each of the five statements had a mean increase of .91. These increases indicate movement in a positive direction toward the desired description of the loving kindness initiative. Of note, due to the small sample size, statistical analysis could not be determined. The goal of nurses being able to enter into transpersonal relationship with patients with pain cannot be measured, but can be inferred as likely due to their modest but increased scores.

Results for the *Self-Rating Survey of Caring* are shown in Table 2 below.

Table 2

Self-Rating Survey of Caring

Caring Statement	Pre-Test (n=5)	Post-Test (n=4)	Change
1. I see that care is provided with loving kindness.			
6 Value	3	0	
7 Value	2	4	
Average Score	6.4	7	+0.6
2. I am authentically present and am able to honor subjective inner life-world of self/other.			
4 Value	1	0	
6 Value	3	0	
7 Value	1	4	
Average Score	5.8	7	+1.2
3. I honor faith help instill hope, and respect the belief system of self and patient as part of my care.			
6 Value	3	0	
7 Value	2	4	
Average Score	6.4	7	+0.6
4. I develop and sustain loving, trusting, and caring relationships.			
6 Value	2	0	
7 Value	3	4	
Average Score	6.6	7	+0.4
5. I allow for expression of positive and negative feelings—authentically listening to patient's story.			
6 Value	3	0	
7 Value	2	4	
Average Score	6.4	7	+0.6
6. I respond to each patient as a whole person, helping to take care of all needs and concerns, and helping to problem-solve using self and caring-healing practices via all ways of knowing, being/becoming.			
6 Value	4	0	
7 Value	1	4	
Average Score	6.2	7	+0.8

Caring Statement	Pre-Test (n=5)	Post-Test (n=4)	Change
7. I engage in transpersonal teaching and learning; staying in patient's frame of reference—shift toward coaching model.			
6 Value	2	0	
7 Value	1	2	
UNKNOWN	0	2	
Average Score	5.6	7	+1.4
8. I co-create a healing environment at all levels that recognizes the connection between body, mind, and spirit.			
4 Value	2	0	
6 Value	2	2	
7 Value	1	2	
Average Score	5.4	6.5	+1.1
9. I reverentially assist with basic needs as sacred acts, touching mindbodyspirit of the patient; sustaining human dignity.			
4 Value	1	0	
5 Value	1	0	
6 Value	2	0	
7 Value	1	4	
Average Score	5.6	7	+1.4
10. I am open to the spiritual, mystery, unknowns—allowing for healing and miracles and convey this to the patient/family. I am accepting of their beliefs regarding a higher power.			
5 Value	1	0	
6 Value	3	0	
7 Value	1	4	
Average Score	6	7	+1.0

From Table 2, it is again seen that the scores pre-project are above average with a mean of 6, increasing to 6.7 on post-test, thus an increase of .75. Again, an increase was observed in scores for each of the ten statements from pre-test to post-test. There was an increase in each of the ten statements scores ranging from of .4 -7.4, with a mean increase of 1.4. This indicates a movement in a positive direction toward the caring behaviors. Statements 5, 6, 7, and 8 relate to

Caritas #6, but specifically statement 6 which showed an increase of .8 on post-test with four answering 7, the highest ranking. Statistical significance cannot be established due to small sample size. It was anticipated that a positive change would occur in the nurses' knowledge base regarding Caritas Processes, self-care, and understanding of the experience and needs of the chronic patient. Improvement in nurses' rating of all these was demonstrated.

On the back of the *Self-Rating Survey of Caring paper*, nurses answered the open-ended question "Describe what it is you do when you care for a patient." On the *Pre-Test* a few themes emerged: establishing a trusting, respectful relationship with the patient, the importance of greeting and introducing self, smiling, eye contact, starting a trusting relationship, listening closely, showing respect, forgetting all distractions, allowing time for patient to converse and express needs, starting conversation where the patient is, asking what the patient's goal is for the day, identification of the patient's needs and diagnosis, paying attention to clues in environment, family involvement, and the need for body, mind and spirit to be incorporated into care. Responses to the same question on *Post-Test* were: "No change in view of caring"; "To continue the care and give with understanding"; "A nurturing role in which the needs of patient are considered and assistance rendered"; "Create an atmosphere of immediate safety and calm including mental and physical health"; and "We are all on a spiritual journey; some of us see it and continue the knowledge of growth towards the fulfillment of oneness, love and connection to our world. We are all connected by that unique power that continues to mystify us—Life! Tune in to the frequencies of all that is—God Bless!"

Results of the *Post Survey of Nurses* administered after the project conclusion are shown in Table 3 below.

Table 3

Post-Survey for Nurses

QUESTIONS	1	2	3	4	5
	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. Having chronic pain changes a person but the environment can have an important effect.					5
2. The best way the nurse can help the chronic pain patient may be the use of transpersonal caring.				1	4
3. Finding meaning in illness, suffering & pain helps the patient gain self-knowledge, self-caring, self-healing & restoration of harmony.					5
4. Caritas #6 involves creative problem-solving for caring decision-making; the nurse can help the patient recognize novel ways to deal with the pain utilizing complementary modalities.					5
5. Caritas #1 involves the nurse focusing first on care of self.					5
6. I evaluated my own self-care and set goals after our first session.			1	1	3
7. I planned an opportunity for 10 minutes of self-care at least 4 days/week.		1		3	1
8. I used a touchstone to center myself when stressed by altering my breathing to elicit a relaxation response.	1	1		2	1
9. I am able to center myself now when stressed.		1		2	2
10. As a result of improved self-care and loving-kindness toward self, I use loving-kindness with my co-workers.				1	4
11. As a result of improved self-care and loving-kindness toward self, I use loving-kindness with my patients in the Pain Center.				1	4
12. I feel that I provide transpersonal care to my patients in the Pain Center.				1	4

It can be seen from Table 3 that the nurses demonstrated understanding of the chronic pain experience and use of Caritas #6 to assist the patient with problem-solving for their caring decision-making by their high rankings on question 4 in particular, as well as questions 1, 2, 3, and 12. High rankings on questions 5, 6, 7, 8, 9, 10, and 11 demonstrated use of Caritas #1. There was more variation in rankings for questions 6, 7, 8, and 9 which may indicate the nurses realize their need for more attention to self-care practices. It was anticipated that in the cognitive domain a positive change would occur in the nurses' knowledge base regarding Caritas Processes, self-care, and understanding of the experience and needs of the patient with chronic pain. In the affective domain, rating of positive behavior was expected regarding self-care and the internalization of Caritas #1, with attendant behavior change to exemplify loving kindness to others, particularly other staff members and their patients. Also, an understanding of the chronic pain experience and use of Caritas #6 to assist the patient with problem-solving for their caring decision-making was demonstrated by responses to question 4 in particular, and questions 1, 2, 3, and 12 on the *Post-Survey for Nurses* results. The responses to the twelve measures at the completion of the project were all positive, which implies the nurses have an established Caritas Consciousness. The comments provided by the nurses were: "Our pain department greatly thanks you" and "Thank you for helping us with our patients." There was positive feedback, both verbal and non-verbal, and a discussion of future potential initiatives to sustain their growth in Caritas Consciousness.

Overall, it was anticipated that a positive change would occur in the nurses' knowledge base regarding self-care, Caritas Processes, and their understanding of the experience and needs of the patient with chronic pain. A positive behavior change was expected regarding self-care and the internalization of Caritas #1, with attendant behavior change to improve self-care

practices and exemplify loving kindness to others, particularly other staff members and their patients. This was demonstrated by the change from pre- to post-surveys for the two tools used. The high ratings for statements relating to Caritas #6 on the *Post-Survey for Nurses*, plus positive comments on the survey, support the conclusion that the nurses are on a Caritas Consciousness journey for themselves and for their patients. Since the Caritas Processes are interrelated, improvement in one will likely influence the others. Thus, achieving a Caritas Consciousness can be expected to result in improved care of their patients through the use of transpersonal caring. Despite time constraints which changed the implementation plans, the purpose of the project was accomplished via three educational sessions, and ongoing email support.

V. SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Summary

Starting with Session 1 this was a seven-week journey, but a journey that will hopefully continue for these nurses. They have learned the value of self-care, how to center oneself and relax when stressed instead of reacting. This alone can be invaluable in a stressful profession. Learning to reflect before, during, and after action is another tool they now possess. They have engaged in reflective journaling. The open-ended question in which the nurses wrote what it is they actually *do* when caring for a patient showed the project may have helped them focus on what caring really means, and its importance. It was difficult to note change, however. If anything, their initial responses were more detailed, possibly reflective of the extra time they had at the beginning of Session 1, as opposed to limited time at the end of Session 2.

In Session 2, an educational PPT explored what we know about the chronic pain experience, how it changes a person, and the modalities for treating it. Participants received an overview of the evidence regarding modality effectiveness. The sessions were judged a success

based on their level of participation, verbalization of understanding, and comments. The nurses were engaged and eager to contribute personal experiences. One nurse shared a recent experience in which “Something caused me to give this patient a hug. When she returned next time, she thanked me and told me how very important this was; the only good thing that had happened to me!” The nurse realized how this simple act in use of self to connect with this patient conveyed her transpersonal caring. It was a powerful insight. Session 3 provided further clarification of the linkage between Caritas #1 and #6 and an opportunity for discussion of future possibilities for this staff and possibly the rest of the hospital

Limitations

The main limitation of the project was the small group of five nurses, with one absent for Session 2. The lack of coding the surveys was another, as coding would have enabled comparison of pre- and post-surveys to observe growth for each individual nurse. The first was beyond this author’s control; the latter might be planned differently in the future. Another limitation was an attempt to do too much within the time constraints. The knowledge base regarding chronic pain management was extensive. A focus on Caritas #1 alone would have been more manageable and perhaps more meaningful for the nurses, as there would be more time to share experiences with centering, meditating and journaling, etc. Four sessions and shorter intervals between sessions would have been better, but this was not possible in this setting.

Conclusions

Much was accomplished, as demonstrated by the positive ratings on the first two surveys described above, and the third, the *Post-Survey* (Appendix J) which measured overall outcomes. Lack of statistics for two of the tools makes interpretation of findings of the surveys difficult, as does the small sample size. The *Watson Self-Rating Score* is the nurses’ version of the WCPS

and it has excellent reliability and validity, and is being used in multisite clinical research studies. One might infer that this lends a degree of support to the findings on the adapted tool used in this project since it is a different version of the WCPS. There is inherent difficulty when attempting to measure subjective constructs as discussed by Tierney et al. (2016) who interviewed healthcare professionals to discuss compassionate care measurement and identified the following problems: difficulty distinguishing compassionate care from other concepts, relying on informal indicators, making the subjective objective, incorporating external influences, and putting measurement tools to use (p. 22).

But the authors of the *Caring Factor Survey* discuss the importance of measuring patients' perceptions of care and their hope that measurement of patients' connectedness to the direct care provider can become a central outcome measure (Nelson, Turkel & Watson, 2010). Measurement of the patient's perception of nursing care needs to be explored further. Patient satisfaction is linked to hospital ranking and reimbursement which is of great value to the hospital system. If the nurse engages in transpersonal caring, it can most positively affect patient satisfaction.

The essential tools for success with the long-term goals have been provided and this should be viewed as a journey for the nurse and the unit. The stage has been set for nurses to join with their patients who journey with pain. Ultimately, improved outcomes for patients and nurses should be anticipated and the relationship of nurses' Caritas Consciousness to patient outcomes could be researched in the future with use of the WPCS in the patient population.

Recommendations

More education about use of various complementary and integrative modalities could be helpful to the staff. Guidelines were provided to help patients with decisions about these

modalities, but the more knowledge nurses have, the better they will be able to guide and coach the patient with helpful techniques from various modalities. Examples of modalities the nurse can implement are imagery, breathing and centering techniques, and progressive muscle relaxation. The nurse can make fruitful use of time by teaching techniques when waiting with the patient and during a procedure. Increasing the comfort level of the nursing staff to teach these techniques would be desired. The concept of coaching as a more advanced form of teaching might be explored and practiced with the nurses. Ideas to make the physical environment a healing place include posting inspirational messages and photographs depicting the beauty of nature in the halls and strategically in the treatment rooms. These can serve as focal points for the patient who is anxious and in pain. Additional suggestions are providing instructional materials in the waiting area and a list of resources for patients, including the pain support group flyer. Help to start a support group at the Center was offered. The self-help handbook by Caudill (2016) can be purchased and made available.

To sustain the Caritas initiative, nurses could have monthly meetings, or a Caritas Club, focusing on ways to further promote the implementation of Caritas #1 (which is at the core) and Caritas #6 in the Pain Center. On-line chats could be tried. Innovation will be limited only by the creativity of the nursing staff. If they feel inspired to move forward with this Caritas initiative, both long-term goals will be achievable and sustainable. Self-care was the start and the rest will follow, depending on the level of interest and motivation. It will likely take some leadership to promote continued interest. The need for Caritas is evident and the nurses at this Pain Center can model a healing environment in which the nurses treat all patients, at all encounters, with transpersonal caring. This is a lofty goal, but possible and sustainable.

The self-care inherent in Caritas #1 was taught and practiced in this project with nurses at a Pain Center, but this can be done with nurses in any unit or setting. The self-care component of this project could be replicated wherever there are nurses. It could also be expanded in scope to include each of the other Caritas Processes, once a Caritas Consciousness has been achieved by the nurses. Self-care could be expanded to more sessions and on a regular basis. There are infinite possibilities to explore if one wishes to apply Watson's theory with nurses caring for various populations. This project is an example of applying specific Caritas Processes to meet the needs of a specific group of nurses working with patients in a specialty unit. It is hoped that Watson's concepts and language will be contagious! Ultimately, this can help nurses make a positive difference in patient care and improved work and personal satisfaction for the nurses themselves. Periodic updates or retreats to sustain the nurses are recommended.

VI. REFERENCES

- American Association of Colleges of Nursing (AACN). (2006b). *Essentials of doctoral education for advanced nursing practice*. Retrieved from <http://www.aacn.nche.edu/publication/positions/DNPEssentials.pdf>
- American Nurses Association. (2001). *Code of Ethics with Interpretive Statements*. Silver Spring, MD.
- American Society for Pain Management Nursing. (2015, September 16). Position Statement: *Statement on Nurses' Use of Integrative Therapies for Pain*.
- Bandura, A. (1977). *Social learning theory*. Englewood Cliffs, NJ: Prentice Hall, Inc.
- Bailey, D. (2009). Caring defined: a comparison and analysis. *International Journal for Human Caring*, 13(1), 16-31.
- Barrie, J. (2011). Patient empowerment and choice in chronic pain management. *Nursing Standard*, 25(31), 38-41.
- Braden, J. B., & Sullivan, M. D. (2008, Dec. 9), Suicidal thoughts and behavior among adults with self-reported pain conditions in the national comorbidity survey replication. *Journal of Pain*, 9(12), 1106-1: 780115.
- Brant, J. M., Mohr, C., Coombs, N., Finn, S., & Wilmarth, E. (2017). Nurses' Knowledge and Attitudes About Pain. *Pain Management Nursing*, 18(4), 214-223.
- Broschous, C., Spigelmyer, P., Breckenridge, D. (2015). Effects of bedtime nursing care on perceptions of caring for patients on a rehabilitation unit: a pilot study. *International Journal for Human Caring*, 19(4), 56-61.
- Burnell, L., & Agan, D. L. (2013, May-August). *International Journal of Caring Science*, 6(2), 180-187.

Carpenter, J. J., Hines, S. H., & Lan, V. M. (2016). Guided imagery for pain management in postoperative orthopedic patients: an integrative review. *Journal of Holistic Nursing*.

December 2017, 35(4), 342-351.

Caudill, M. (2016). *Managing Pain Before It Manages You (4th ed.)*. New York, NY: The Guilford Press.

Cayea, D., Perera, S., & Weiner, D. (2006, November). Chronic Low Back Pain in Older Adults: What Physicians Know, What They Think They Know, and What They Should Be Taught. *Journal of the American Geriatrics Society*, 54(1), 1772-1777.

Cederberg, J. T., Cernvall, M., Dahl, J., von Essen, L., & Ljungman, G. (2016). Acceptance as a Mediator for Change in Acceptance and Commitment Therapy for Persons with chronic Pain? *International Journal of Behavioral Medicine*, (23), 21-29.

Chism, L. (2012). *The Doctor of nursing Practice: A guidebook for role development and professional issues (2nd ed.)*. Burlington, MA: Jones and Bartlett.

Clark, C. S. (2003). The transpersonal caring moment: evolution of high ordered beings. *International Journal for Human Caring*, 7(3), 30-39.

Clark, C. S. (2016). Watson's human caring theory: pertinent transpersonal and humanities concepts for educators. *Humanities 2016*. 5(21)1-12.

Clift, M. (2015). Compassion takes commitment. *Nursing Standard*. London 30(13), 64.

Corsio D. (2018). Kissing the wrong frog: exploring common factors in pain management. *Pain Week Journal*. Vol. 5, Q2, pp. 38-48. Posted January 30, 2018.

Costello, M., & Barron, A. M. (2017). Teaching compassion: incorporating Jean Watson's Caritas Processes into a care at the end of life course for senior nursing students.

International Journal of Caring Sciences, September-December 2017, 10(3), 1113-1117.

- Crane, P. J., & Ward, S. (2016). Self-healing and self-care for nurses. *AORN Journal*. November 2016, *104*(5), 386-400.
- Cumbie, S.A. (2001). The integration of mind-body-soul and the practice of humanistic nursing. *Holistic Nursing Practice*, *15*(3), 56-62.
- Dorsey, C., Phillips, K. D., & Williams, C. (2001). Adult sickle cell patients' perceptions of nurses' caring behaviors. *The ABNF Journal*, Sept/Oct, *12*(5), 95-100.
- DiNapoli, P., Nelson, J., Turkel, M., & Watson, J. (2010). Measuring the Caritas Processes: Caring Factor Survey. *International Journal for Human Caring*, *14*(3), 15-20.
- Drake, G., & Williams, A. C. (2017). Nursing education interventions for managing acute pain in hospital settings: a systematic review of clinical outcomes and teaching methods. *Pain Management Nursing*, *18*(1), 3-15.
- Fargo (2018). Mindful meditation: being aware of pain, instead of being distracted from it. *Pain Week Journal*. Posted March 7, 2018.
- Fawcett, J., Watson, J., Neuman, B., Walker, P. H., & Fitzpatrick, J. J. (2001). On nursing theories and evidence. *Journal of Nursing Scholarship*. Second Quarter 2001, 115-119.
- Felicilda-Reynaldo, R. F. (2016). Taking care of ourselves to take care of others [Editorial]. *MEDSURG Nursing*, *26*(3), May-June 2016, 143-144.
- Ferrell, B., & Coyle, N. (2008). The nature of suffering and the goals of nursing. *Oncology Nursing Forum*, *35*(2), 241-247.
- Fine, P. (2011). Long-term consequences of chronic pain: mounting evidence for pain as a neurological disease and parallels with other chronic disease states. *Pain Medicine*, *12*: 996-1004.

Gilbert, P. (Ed.). (2005). *Compassion: Conceptualizations, Research, and Use in Psychology*.

Retrieved from Google Scholar, e-book, New York, NY: Routledge.

Gillespie, G. L., Houchell, M., Mattei, J., & Rose, L. (2012). Caring in pediatric emergency nursing. *Research and Theory for Nursing Practice: An International Journal*, 26(3), 216-232.

Hawker, G. A. et al. (2011). Measures of adult pain. *Arthritis Care & Research*. November 2011, 63(S11), 240-252.

Healthy People 2020. U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved from <https://www.healthypeople.gov/2020>

Henry, S. (2017). Patient treatment goals: when patients and providers disagree. *Clinical Journal of Pain*, 33(11): 955-961.

Henson, J. S. (2017). When compassion is lost. *MEDSURG Nursing*, March-April 2017, 26(2), 139-142.

Hunter, L. (2016). Making time and space: the impact of mindfulness training on nursing and midwifery practice. A critical interpretative synthesis. *Journal of Clinical Nursing*, 25, 918-929.

Hunter, L. (2017). Mindfulness training can reduce depression and anxiety among nurses. *Evidence Based Nursing*, 20(2), 57.

Interagency Pain Research Coordinating Committee (2016). *National Pain Strategy: A Comprehensive Population Health-Level Strategy for Pain*.

International Association for the Study of Pain (Ed.). (2017). *International Association for the Study of Pain webpage*. Retrieved May 16, 2018 from [http://www.iasp-](http://www.iasp-pain.org)

[pain.org](http://www.iasp-pain.org)>Education>Content

Institute of Medicine (Eds.). (2011). *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research*. Washington, DC: Government Printing Office.

Joint Commission Perspectives (2014). *Clarification to Standard PC. 01.02.07. 34(11)*, 11.

Kabat-Zinn, J. (1990). *Full Catastrophe Living: Using the Wisdom of Your Body and Mind to Face Stress, Pain and Illness*. New York, NY: Delacorte Press.

Kachan, D., et al. (2017). Prevalence of mindfulness practices in the U.S. workforce—National Health Interview Survey. *Preventing Chronic Disease, 14(1)*.

Katz, J., Rosenbloom, B. N., & Fashlaher, S. (2015). Chronic pain psychopathology and DSM-5 symptom disorder. *Canadian Journal of Psychiatry, 60(4)*. Retrieved from doi: 10.1177/070674371506000040.

Kee, J. F., Hayes, E. R., & McCuiston, L. E. (2012). *Pharmacology—A Nursing Process Approach* (7th ed.). St. Louis, MO: Elsevier Saunders.

Kehoe, M. H. (2006). Embodiment of hospice nurses—a metasynthesis of qualitative studies. *Journal of Hospice and Palliative Nursing, 8(3)*, 137-146.

Kirsh, K. L., & Fishman, S. M. (2011). Multimodal approaches to optimizing outcomes of chronic pain. *Pain Medicine, 12*(IssueS), pp. S1-S11.

Kramer, M., Brewer, B. B., & Halper, D. (2014). The evolution and development of an instrument to measure essential professional nursing practices. *JONA, 44(11)*, 569-576.

- Kret, D. (2011). The qualities of a compassionate nurse according to the perceptions of medical-surgical patients. *MedSurg Nursing*, January-February 2011, 20:1, 29-36.
- Lazarus, R. S., & Folkman, S. (1984). *Stress, Appraisal, and Coping*. New York, NY: Springer Publishing Company, Inc.
- Lee, G. K. (2010). Contributing Factors of Depression for Individuals with Chronic Musculoskeletal Pain in Workers' Compensation Settings—An Ecological Conceptualization in *Rehabilitation Counseling Intervention*, 76(1), 3-12.
- Lown, B. A., Rosen, J., & Marttila, J., (2011). An Agenda for Improving Compassionate Care: A Survey Shows About Half of Patients Say Such Care Is Missing. *Health Affairs*, 30(9), 1772-1778.
- McCaffrey, M., & Ferrell, B. (1997). Nurses knowledge of pain assessment and management: how much progress have we made? *Journal of Pain and Symptom Management*, 14(3), 175-188.
- Mersky, H. & Bogduk, N. (Eds.). (1994). *Classification of Chronic Pain (2nd ed.)*. IASP Task Force on Taxonomy. Seattle: IASP Press.
- Myers, R. E. (2017). Cultivating mindfulness to promote self-care and well-being in perioperative nurses. *AORN Journal*, March 2017, 105(3), 259-266.
- National Centers for Health Statistics. (2006). *Chartbook on Trends in the Health of Americans Special Feature: Pain*. Retrieved from <http://www.cdc.gov/nchs/data/hus/hus06.pdf>
- Neff, K. D. (2003). The development and validation of a scale to measure self-compassion. *Self and Identity*, 2(223-250).
- Neff, K. D., Kirkpatrick, K. L., & Rude, S. S. (2007). Self-compassion and adaptive functioning and psychological functioning. *Journal of Research in Personality*, 41(139-154).

- Nelson, Turkel & Watson. (2010). Caring Process Factor Survey. In Nelson & Watson (Eds.), *Measuring caring: international research on caritas and healing*. (2011). New York, NY: Springer Publishing.
- Pain Medicine (2005). *Management of Chronic Pain Syndromes: Issues and Interventions*. 8(S1-S-21).
- Parker, D. J. (2015) *The Science of Compassionate Care*. Carrier Clinic. Retrieved from www.njamha.org/.../2015Presentations/.../TheScienceofCompassionateCareNJAAHM...TheScienceofCompassionateCare. Donald J. Parker.
- Partners Against Pain. People in Pain Network*. Retrieved from <http://www.partnersagainstpain.com/pain> advocacy.
- Peter D. Hart Research Associates. *Americans in Pain*. p. 3. Retrieved from <http://www.researchamerica.org/uploads/poll2003pain.pdf>
- Quinlan-Colwell, A. D. (2009). Understanding the paradox of patient pain and patient satisfaction. *Journal of Holistic Nursing*, 27(3), 177-182.
- Quinn, J. F., Smith, M., Ritenbaugh, C., Swanson, K., & Watson, J. (2003). Research guidelines for assessing the impact of the healing relationship in clinical nursing. *Alternative Therapies in Health and Medicine*, May/June 2003. 9(3), A65-79.
- Ray, M., & Turkel, M. (2014). Caring as emancipatory nursing praxis: the relational caring complexity. *Advances in Nursing Education*, 37(2), 132-146.
- Ross, A., Bevans, M., Brooks, A., Gibbons, S., & Wallen, G. (2017, March) Nurses and health-promoting behaviors, knowledge may not translate into self-care. *AORN Journal*, 105(3), 267-275.

- Rossillo, K. (2018). Caritas Education: Theory to Practice...2018 National Teaching Institute Research Abstracts Presented at the AACN National Teaching Institute in Boston, Massachusetts, May 21-24, 2018. *American Journal of Critical Care*, 27(3), e14-e15. doi:10.4037/ajcc2018805
- Shaw, S., & Lee, A. (2010, March). Student Nurses' Misconceptions of Adults With Chronic Nonmalignant Pain. *Pain Management Nursing*, 11(1).
- Sitzman, K., & Watson, J. (2014). *Caring Science, Mindful Practice, Implementing Watson's Human Caring Theory*. New York, NY: Singer Publishing.
- Sitzman, K. (2017). Evolution of Watson's Human Caring Science in the digital age. *International Journal for Human Caring*, 21(1), 46-52.
- Sitzman, K. (2002). Interbeing and mindfulness: a bridge to understanding Jean Watson's Theory of Human Caring. *Nursing Education Perspectives*, 23(3), 118-123.
- Sitzman, K. (2007). Teaching-learning professional caring based on Jean Watson's Theory of Human Caring. *International Journal of Human Caring*, 11(4), 8-16.
- Slatyer, S., Williams, A. M., & Michael, R. (2015). Seeking empowerment to comfort patients in severe pain: A grounded theory study of the nurse's perspective, *International Journal of Nursing Studies*, 52: 229-239.
- Smith, M., Kemp, J., Hemphill, L., & Vojir, C. (2002). Outcomes of therapeutic massage for hospitalized cancer patients. *Journal of Nursing Scholarship, Third Quarter 2002*, 34(4), 257-262.
- Sullivan, M. J., et al. (2001). Theoretical perspectives on the relation between catastrophizing and pain. *The Clinical journal of Pain*, 17: 52-64. Philadelphia, PA: Lippincott Williams & Wilkins, Inc.

- Terry, M. L., & Leary, M. R. (2011). Self-compassion, self-regulation, and health. *Self and Identity, 10*, 352-362. <http://dx.doi.org/DOI: 10.1080/15298868.2011.558404>
- The American Academy of Pain Medicine. (n.d.). *AAPM Facts and Figures on Pain*. Retrieved from <http://www.painmed.org/patientcare/facts-on-pain/#icidence>
- The American Academy of Pain Medicine. (2011). Global Industry Analysis Inc. Report. Retrieved from http://www.org/PatientCenter/Facts_on_Pain.aspx#chronic
- The American Academy of Pain Medicine. (2017, June 21). Resolution: *AMA House of Delegates Adopts AAPM Resolution on Future of Pain Care*.
- Thorn, B. (2004). *Cognitive therapy for chronic pain*. New York, NY: The Guilford Press.
- Thorn, B. E., & Dixon, K. E. (2007). Coping with chronic pain: a stress-appraisal coping model. In Thorn, B. (2007) *Coping with Chronic Illness & Disability: Theoretical, Empirical, & Clinical Aspects*, pp. 313-335.
- Tierney, S., et al. (2016). Measuring compassionate care: views of healthcare staff. *NursingManagement, 238*, 22.
- Treede, R. D., et al. (2015) A classification of chronic pain for ICD-11. *Pain, 2015 Jun;156(6):1003-7*. doi: 10.1097/j.pain.000000000000160. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/25844555>
- Turk, D. C., & Gatchel, R. J. (2002). *Psychological Approaches to Pain Management: A Practitioner's Handbook (2nd ed.)*. New York, NY: The Guilford Press.
- Turkel, M. C., & Ray, M. (2004). Creating a caring practice environment through self-renewal. *Nursing Administration Quarterly, 28(4)*, 249-254.
- Valente, S. M., & Saunders, J. (2005, November). Screening for depression & suicide self-report instruments that work. *Journal of Psychosocial Nursing 43*.

- Walton, D. M. (2018). A reconceptualization of the pain numeric rating scale: anchors and clinically important differences. *Journal of Hand Therapy, 31*(2018), 179-183.
- Watson, J. (2009). Caring Factor Survey. In *Assessing and Measuring Caring in Nursing and Health Sciences* (2nd Ed.). Chapter 25, p. 253-257.
- Watson, J. (2005). *Caring Science as Sacred Science*. Philadelphia, PA: F.A. Davis Company.
- Watson, J. (2012). *Human Caring Science—a Theory of Nursing* (2nd ed.). Sudbury, MA: Jones & Bartlett Learning.
- Watson, J. (2002). Intentionality and caring-healing consciousness: a practice of transpersonal nursing. *Holistic Nursing Practice, 16*(4), 12-19.
- Watson, J. (2008). *Nursing: The Philosophy and Science of Caring* (2nd ed.). Boulder, CO: University of Colorado Press.
- Watson, J., & Brewer, B. (2015). Caring science research—criteria, evidence, and measurement. *JONA 45*(5), 235-236.
- Watson, J., & Foster, R. (2003). The Attending Nurse Caring Model: integrating theory, evidence, and advanced caring-healing therapeutics for transforming professional practice. *Journal of Clinical Nursing, 12*, 360-365.
- Wells, N., Pasero, C., & McCaffery, M. (2008). Improving the Quality of Care Through Pain Assessment and Management. In Hughes, R.G. (Ed.). *Patient Safety and Quality: An Evidence-Based Handbook for Nurses* (pp. 1-21). Rockville, MD: Agency for Healthcare Research and Quality.
- Weir, S. (n.d.). Critique of Jean Watson's Theory of Human Caring. Discussion. Retrieved from <http://www.sharonwehr.weebly.com>

- Willerding, N. J. (2004). *A survey of personal support workers' knowledge and attitudes about pain in nursing home residents*. (Published Master's Thesis). D'Youville College, Buffalo, NY. Retrieved from (ProQuest, UMI Number: 1423676).
- Williams, R., Hapidou, E., Lin, C., & Abbasi, H. (2007). Examining the pain stages of change questionnaire in chronic pain. *Physiotherapy Canada*, 39(2), 132-141.
- Wu, S., Singh-Carlson, S., Odell, A., Reynolds, G., & Su, Y. (2016). Compassion fatigue, burnout, and compassion satisfaction among oncology nurses in the United States and Canada. *Oncology Nurse Forum*, 43(4), E161-E169.

VII. APPENDICES

APPENDIX A: SAMPLE OF POWERPOINT—SESSION 1

CARING ?

What does it mean?
How does Watson define it?

By: Patricia Hubert, RN, APN, MSN

10 CARITAS PROCESSES

- 6- Creative Use of Self and All Ways of Knowing as Part of the Caring Process: Engage in the Artistry of Caritas Nursing
- 7- Engage in Genuine Teaching-Learning Experience That Attends to Unity of Being and Subjective Meaning—Attempting to Stay Within the Other's Frame of Reference
- 8- Creating a Healing Environment at all Levels
- 9- Administering Sacred Nursing Acts of Caring-Healing by Tending to Basic Human Needs
- 10- Opening and Attending to Spiritual/Mysterious and Existential Unknowns of Life-Death

CARITAS

- Latin word for “cherish”, to appreciate, & give special, if not loving attention to. It represents compassion & generosity of spirit.
- “It connotes something very special, indeed, something that needs to be cultivated and sustained.

(Watson, J., 2008)

Emphasis on:

- Helping a person gain more self knowledge, self-control, self-caring, & inner healing of self, regardless of external condition
- Nurse as co-participant in the human caring-healing of self, regardless of the external health condition
- Relationship between nurse and other

❖ This underlying value system is blended in with the 10 Caritas Processes

10 CARITAS PROCESSES

- 1- Cultivating the Practice of Loving-Kindness and Equanimity Toward Self and Other as Foundational to Caritas Consciousness
- 2- Being authentically present: Enabling, Sustaining, and Honoring the Faith, Hope, and Deep Belief System and the Inner-Subjective Life World of Self/Other
- 3- Cultivation of One's Own Spiritual Practices and Transpersonal Self, Going Beyond Ego-Self
- 4- Developing and Sustaining a Helping-Trusting Caring Relationship
- 5- Being Present to, and Supportive of, the Expression of Positive and Negative Feelings

Transcendence

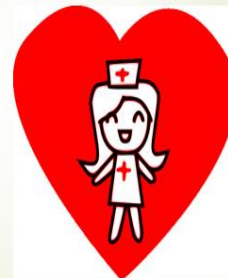
- “The idea of **transcendence** represents options for true human growth and an evolving human consciousness of our relationship with the infinite field of life itself; it offers opportunities to become more fully human & evolve toward greater spiritual depths. The views inherent in these ideas allow one to turn inward and regard oneself & others with reverence & dignity, as spiritual beings capable of contributing to the spiritual evolution of self & civilization.”

(Watson, 2012, p. 59)

Caritas 1: Cultivating the Practice of Loving-Kindness and Equanimity Toward Self and Other as Foundational *Caritas Consciousness*

- A deeply held desire to love and to care in whatever ways are meaningful and helpful in a given moment, within a given situation.
- It is a starting point, a stance, an attitude, an intention, a commitment, and a conscious judgment that manifest itself in concrete acts.
- It is the core concept.
- Creates openings for the development of unique caring/loving kindness identities.
- The temperament of the nurse, temperament of the patient, and other situation-specific factors will influence what the outward expression of caring loving kindness will be, while the inner resolve of the nurse to **care and love** become constant.

How do you show loving kindness to yourself?



What will this look like?

- Staff members will all treat the patient, at all encounters, with transpersonal caring.
- The patient will know there is a caring connection.
- Staff members will be treated with the same transpersonal caring
- Staff members will begin their own journey toward self-loving kindness

Touchstones for Setting **Intentionality** & Consciousness for Caring & Healing

(Jean Watson, 2008)

- Use Caring in the Beginning
- Caring in the Middle
- Caring in the End
- Care continuing

How to get there? It starts with **YOU!**

- To be guided by *Caritas Consciousness* one needs skills
- **Practice Mindfulness**, which is about being present in the moment, holding off judgment
- Can be cultivated by **meditation** practice
- Learn how to **respond to stress vs. reacting to it**
- Nurses are at risk of compassion fatigue—need to keep energy up & replenish your stores for your personal & professional life
- Watson developed “touchstones” for setting our intentionality and consciousness for caring healing (see handout)
- These touchstones can be affirmations and a tool to help you step into this *Caritas Consciousness*
- Need skills to equip us to invoke & participate in becoming & holding the radiating field of loving-caring consciousness that affects the whole
- Reflect on your experiences with the meditation and your ability to center yourself when stressed during the day

Transpersonal caring –nurse becomes the environment!

- People need each other in a caring, loving way. Love and care are universal givens.
- Note from the diagram Nurse own causal past in the phenomenal field of the present moment
- Nurse considers the Patient, with his/her causal past in the phenomenal field of the present moment
- Then interacts with the Patient and impacts the present caring moment and possibly the future
- The shared moment of the present has the potential to transcend time & space & the physical, concrete world as we generally view it

APPENDIX B: WAYS TO ACHIEVE CARITAS #1

Sustaining humanistic-altruistic values by practicing loving-kindness, compassion and equanimity with self and others.

Examples of Self-Care

- Build your schedule opportunities for self-care
 - Quiet walks by yourself
 - Little meditative periods are opportunities for a quiet, reflective, peaceful time
 - Time and space for meditation
 - Reading for relaxation
 - Some light exercise (yoga, stretching,...)
 - A hobby
 - Listening to music you enjoy

Benefits of Self-Care

- You develop a fresh perspective for yourself
- You enhance your creativity in dealing with challenges
- You build self-confidence
- Balance and well-being
- Career satisfaction
- Coping mechanisms
- Health and vibrancy

Self-Care

- We must learn to manage our stressors and be good to ourselves
- We must “walk the talk” and model optimal health
- Make wise food choices that nourish our bodies
- Maintain a healthy weight
- Avoid high risk behavior (overtime is a high-risk behavior!)

Methods

- Color therapy
- Aromatherapy
- Music therapy
- Pet therapy
- Laughing yoga
- Joke for the day/quote for the day
- Holistic therapy
- Group exercise
- Meditation/quiet rooms on units

By: Lisa Flack & Donnean Davison Thrall, NY State Caritas Consortium, Siena College, 2017.

APPENDIX C: GUIDELINES FOR APPLYING CARITAS #1

**Guidelines to help you in applying Caritas 1**

- ❖ Daily centering time for a minimum of 10 minutes (could be any meditation, any prayer or exercise time with centering *intention*. (This can vary by day, but is not to be skipped). Try to make it an actual meditation at least 6 days per week.
- ❖ Daily entry in your personal journal
- ❖ Create a list of personal altruistic goals to guide life and practice—do this after the first day of centering
- ❖ This list is to be revisited at the end of each work week and used to evaluate progress toward goals
- ❖ Compassionately examine personal behavioral styles, envision what loving kindness might look like in light of who you are and what feels right to you, then consistently try to embody and demonstrate that as your personal expression of engaged caring/loving consciousness
- ❖ Practice loving kindness with yourself *without fail*, even when things don't go well
- ❖ Practice loving kindness with all whom you encounter
- ❖ Release each encounter with gratitude for what you have learned and experienced, and then move forward

By: Patricia M. Hubert (2017).

APPENDIX D: SAMPLE POWERPOINT—SESSION 2

USE OF WATSON'S TRANSPERSONAL CARING WITH THE PERSON IN CHRONIC PAIN


By Patricia Hubert, RN, APN, MSN, PNP, CSN

THE NATIONAL PAIN STRATEGY: A VISION

- To decrease the prevalence of pain across its continuum from acute to high-impact chronic pain and its associated morbidity and disability across the lifespan.
- The intent is to reduce the burden of pain for individuals, their families, and society as a whole.

IMPACT

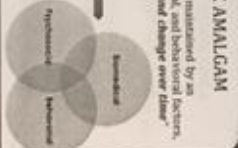
The major problem, a barrier of pain in chronic pain is the lack of understanding of the mechanisms of chronic pain. Because of shortcomings in the availability of effective treatments, & inadequate knowledge of the pathophysiology of chronic pain, there have been many attempts to manage pain. "It is likely that most or nearly every person in the world who has chronic pain is not getting what is necessary to control it." (Global Pain in America [2011] by American Pain Society, 2011, p. 2)



A COMPLEX AMALGAM

"The experience of pain is a complex amalgam sustained by an interdependent set of biological, psychological, and behavioral factors, whose relationships are not static but evolve and change over time" (Tuck & Bennett, 2002, p. 23)

- Consider the pain patient as a holistic being
- Consider the effect of environment on patient




NATIONAL PAIN STRATEGY

INTERAGENCY PAIN RESEARCH COORDINATING COMMITTEE (IPRCC) FINAL REPORT—2011

- Often, the cause of chronic pain is uncertain
- The mechanisms by which it persists are complex
- Can affect people of any age and may begin with an injury, disease process, or procedure that evolves into a persistent painful condition
- There is need to better understand the factors that cause pain to become persistent & to develop & apply measures to prevent acute pain & its transition to a chronic state
- Existing knowledge could be used more effectively to reduce the numbers of people who suffer

WHAT WE DO KNOW ABOUT CHRONIC PAIN

- IT CHANGES A PERSON



WATSON'S TRANSPERSONAL CARING

What lens change is necessary "to see" or "to be"?



Cartians 1 - Sustaining humanistic-altruistic values by practicing loving-kindness, compassion and equanimity with self & others. Nurse focuses first then others by practicing loving kindness to self.

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

WATSON'S TRANSPERSONAL CARING

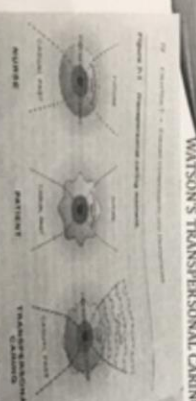


Figure 1-1. Watson's Transpersonal Caring

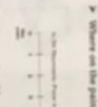
CARING FOR THE CHRONIC PAIN PATIENT

What do I need to know?

- See the patient in the context of their life—how their story
- How do you know patient's situation?
- What is the trajectory of illness for this patient?
- How does the patient view their situation?
- How is their pain impacting functioning & life?
- How can the patient best manage their pain? Why long-term?
- What medications would patient try?
- How efficacious is each one?
- Be aware: Is patient being "over" medicated? Showing signs of aberrant behaviors? (See Scott)

PAIN ASSESSMENT—WHAT ARE YOU FEELING?

- What do you say about your pain?
- Please describe it
- Where on the pain scale? VAS Analog Scale



May be preferable to ask if it is mild, moderate or severe?

How would you describe a "10" on the worst pain possible—what adjective defines it the same way

CARING FOR THE CHRONIC PAIN PATIENT

What do I need to be?

Mindful (assuring safety & comfort while at Pain Center)

Empathetic

Sensitive

Present

Encouraging

A partner

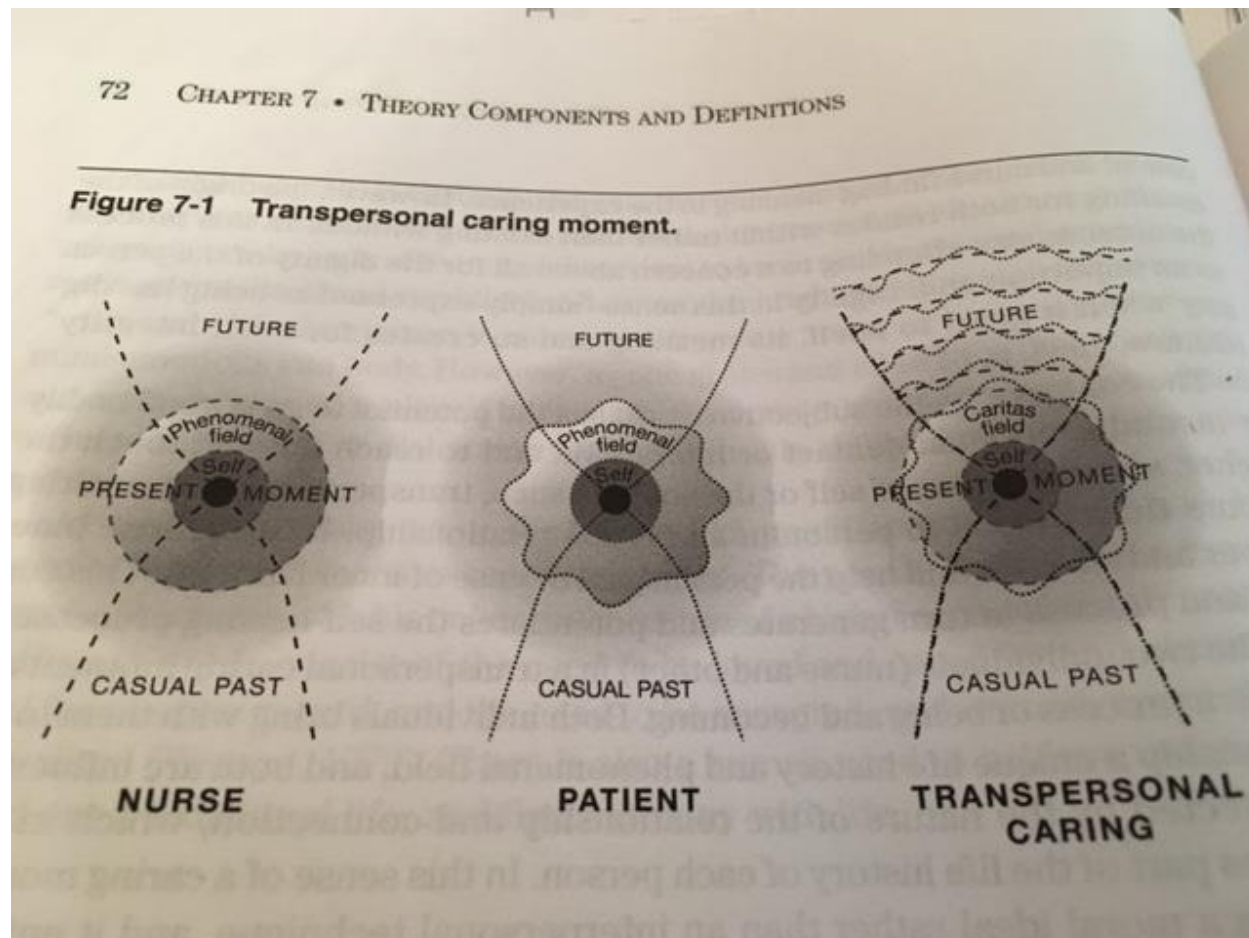
Open to alternative measures for pain relief

Intrusive patient to measures to promote comfort at home, work, & social settings

PAIN ASSESSMENT

- Can you describe the quality, intensity, location, and radiation?
- Tools are not wonderful, but an attempt to quantify
- Pain ratings over time more helpful
- e.g. how would rate pain over past week, over past month, etc.
- If taking pain medicine, ask: Is it working right now?
- Percentage of relief?

APPENDIX E: WATSON'S TRANSPERSONAL CARING



Reprinted, with permission, from Watson, J. (2012). *Human Caring Science—a Theory of Nursing* (2nd ed.). Sudbury, MA: Jones & Bartlett Learning, p. 72.

APPENDIX F: CARITAS #6

Caritas Process #6-Creative use of Self and All Ways of Knowing as Part of the Caring Process; Engage in the Artistry of Caritas Nursing. (Watson, 2008, p. 107)

This represents a deepening of self-awareness and growth in the nurse; then combining the full use of self with the evidence. It combines caring ethics with empiric evidence—commonly referred to as “the art and science of nursing.” The nursing process is our formal method of problem-solving and there has been emphasis on evidence-based practice. Jean Watson observes:

“A wise Caritas practitioner seeks to integrate necessary ‘evidence’ at multiple levels with the wise clinical judgment necessary for addressing individual people with individual life stories and circumstances integrating practitioner and person-patient-family.” (2008, p. 112)

So, what would Caritas 6 look like in the Pain Center?

- **Nursing staff focuses on gaining insight into, attending to, knowing, experiencing, judging: using all ways of knowing.**

The nurse asks: *What do I need to be?*

Mindful (assuring safety & comfort while at Pain Center)

Empathetic

Sensitive

Present

Encouraging

A partner & coach

Open to alternative measures for pain relief

- If one holds higher-thought consciousness, the entire energy field can be, and is being, re-patterned by the nurse’s consciousness.
- The nurse-self, the *Caritas Nurse*, then ***becomes*** the environment, affecting the entire energy field. If I am the environment:
 - ❖ **How can I be a more caring, healing environment?**
 - ❖ **How can I become a safe, healing space for this person? To draw out healing, wholeness?**
 - ❖ **How can my Caritas presence & loving-caring consciousness help align in this moment with the spirit of this person?**
 - ❖ **How can I use my consciousness, my intentionality, my Being, my presence, my voice, touch, face, heart, and so on, for healing?**
 - ❖ **The nurse becomes more attuned to the fact that his/her mood, demeanor, & presence affect the human-environmental caring field.**

This perspective turns toward the universal *Love* we call upon in our lives & our work & our world. (This requires an evolution toward a higher-deeper level of consciousness.)

The nurse works with the patient, as a coach. “In Caritas Coaching the person becomes his or her best source for finding unique creative solutions for meeting goals and a vision for change.” (Watson, 2008, p. 127)

The nurse identifies, *with* the patient, goals related to:

- Pain relief
- Function
- Quality of life & life satisfaction

What do I need to see?

- ✚ The patient in the context of their life—hear their story
 - ✚ The patient’s situation:
 - What is the trajectory of illness for this patient?
 - How does the patient **view** their situation?
 - How is their pain impacting functioning & life?
 - What **meaning** does the pain have?
 - ✚ *Be aware:* is patient depressed? Suicidal? Showing signs of aberrant behavior? (use tools)
 - ✚ How can I help the patient to help him/herself?
- **All staff will work from their own vantage point to problem solve *with the patient*, using all available evidence and wisdom.**
 - ✚ The nurse will continue to learn about all modalities, asking about each one:
 - How does it work?
 - How effective is it?
 - What is the level of evidence?
 - Is it the right fit for this patient based on condition/disease state, age, ability to exercise, preference, etc.?
 - Is this realistic for this patient in terms of availability, payment?
 - The nurse will assist the patient to recognize novel ways to deal with their pain, utilizing all available modalities, complementary/integrative.

In sum, the nurse can definitely take a leading role in helping the patient:

- to feel cared about, as well as cared for
- to be in control of their pain
- to explore new modalities to manage their pain
- to explore ways to promote comfort at home, work & social settings
- to learn new ways to view their pain
- to heal
- to function
- to suffer less
- to transcend the pain their life—becoming a better person, more positive

By: Patricia M. Hubert (2017).

APPENDIX G: NURSES' DEMOGRAPHIC SURVEY

Nurses' Demographic Survey

Please answer the following for the purposes of my Scholarly Project toward completion of the DNP degree at Seton Hall University. Your responses to this and all other surveys will be kept anonymous and are only for the purposes of this study. Indicate the choice which best describes you or your circumstances.

1. Male ____ Female ____
2. Age 20-25 ____, Age 26-30 ____, Age 31-35 ____, Age 36-40 ____, Age 41-45 ____,
Age 46-50 ____, Age 51-56 ____, Age 57-60 ____, Age 61-65 ____, Age 66 and up ____
3. Number of years employed as a Registered Nurse ____ Licensed Practical Nurse ____
4. Basic nursing preparation was Diploma ____, Associates Degree ____, BSN ____,
CNL ____
5. Highest educational level obtained:
Associates Degree- nursing ____ or non-nursing ____
Bachelors- nursing ____, non-nursing ____ (state degree) _____
Master- nursing ____, non-nursing ____ “ “ _____
Doctoral- nursing ____, non-nursing ____ “ “ _____
6. Number of months working in the Pain Center ____
7. I know where the Chilton Watson Room for Centering is located: yes ____, no ____
8. I have used the Watson Room when I needed to Center myself: yes ____, no ____
9. The number of times I have used this room: 1-3 ____, 4-6 ____, 6-10 ____, >10 ____
10. I practice mindfulness regularly (at least a few times per week): no ____, yes ____,
of times per week ____.
11. I practice meditation on a regular basis (at least a few times per week): no ____, yes ____,
of times per week ____.

APPENDIX H: WATSON CARITAS RATING SCORE

WCSR ver. 1b



Watson Caritas Self-Rating Score®

DIRECTIONS: When answering the questions, please consider the overall consistency of human-to-human **Self CARING** you have experienced. Please circle the number for the one best answer.

	Never Always						
I treat myself with loving-kindness.	1	2	3	4	5	6	7
I practice self-care as a means for meeting my own basic needs.	1	2	3	4	5	6	7
I have helping and trusting relationships with others.	1	2	3	4	5	6	7
I create a caring environment that helps me to flourish.	1	2	3	4	5	6	7
I value my own beliefs and faith, allowing for my personal success.	1	2	3	4	5	6	7

I would recommend this hospital to someone I love:

Yes No

We invite you to share any notable caring or uncaring moments you have experienced.

Thank you for completing our survey!

APPENDIX I: SELF-RATING SURVEY OF CARING

Self-Rating Survey of Caring

Directions: Circle the number that best indicates how often you consistently use human-to-human Caring, as defined by Jean Watson's theory in your professional practice with patients. If you do not understand the question circle UNK for Unknown.

	Never					Always			
1. I see that care is provided with loving kindness.	1	2	3	4	5	6	7	UNK	
2. I am authentically present and am able to honor subjective inner life-world of self/other.	1	2	3	4	5	6	7	UNK	
3. I honor faith, help instill hope, and respect the belief system of self and patient as part of my care.	1	2	3	4	5	6	7	UNK	
4. I develop and sustain loving, trusting and caring relationships.	1	2	3	4	5	6	7	UNK	
5. I allow for expression of positive and negative feelings—authentically listening to patient's story.	1	2	3	4	5	6	7	UNK	
6. I respond to each patient as a whole person, helping to take care of all needs and concerns, and helping to problem-solve using self and caring-healing practices via all ways of knowing, being/becoming. (includes complementary/integrative therapies)	1	2	3	4	5	6	7	UNK	
7. I engage in transpersonal teaching and learning; staying in patient's frame of reference—shift toward coaching model.	1	2	3	4	5	6	7	UNK	
8. I co-create a healing environment at all levels that recognizes the connection between body, mind, and spirit.	1	2	3	4	5	6	7	UNK	
9. I reverentially assist with basic needs as sacred acts, touching mindbodyspirit of the patient; sustaining human dignity.	1	2	3	4	5	6	7	UNK	
10. I am open to the spiritual, mystery, unknowns—allowing for healing and miracles, and convey this to the patient/family. I am accepting of their beliefs regarding a higher power.	1	2	3	4	5	6	7	UNK	

On the reverse side please: Describe what it is you *do* when caring for a patient.

* Adapted from DiNapoli, P., Nelson, J, Turkel, M., & Watson, J. (2010). Measuring the Caritas Process Factor survey. *International Journal for Human Caring*, 14(3), 15-20.

APPENDIX J: POST-SURVEY FOR NURSES

Post-Survey for Nurses

Directions: Circle the number which most closely indicates your understanding of best practice in care of the chronic pain patient.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. Having chronic pain changes a person but the environment can have an important effect.	1	2	3	4	5
2. The best way the nurse can help the chronic pain patient may be the use of transpersonal caring.	1	2	3	4	5
3. Finding meaning in illness, suffering & pain helps the patient gain self-knowledge, self-caring, self-healing & restoration of harmony.	1	2	3	4	5
4. Caritas #6 involves creative problem-solving for caring decision-making; the nurse can help the patient recognize novel ways to deal with their pain utilizing complementary modalities.	1	2	3	4	5
5. Caritas #1 involves the nurse focusing first on care of self.	1	2	3	4	5

(See next page)

Directions: Circle the number which most closely indicates your own application of Watson's Caritas #1 and #6.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
6. I evaluated my own self-care and set goals after our first session.	1	2	3	4	5
7. I planned an opportunity for 10 minutes of self-care at least 4 days/week.	1	2	3	4	5
8. I used a touchstone to center myself when stressed by altering my breathing to elicit a relaxation response.	1	2	3	4	5
9. I am able to center myself now when stressed.	1	2	3	4	5
10. As a result of improved self-care and loving-kindness toward self, I use loving-kindness with my co-workers.	1	2	3	4	5
11. As a result of improved self-care and loving-kindness toward self, I use loving-kindness with my patients in the Pain Center.	1	2	3	4	5
12. I feel that I provide transpersonal care to my patients in the Pain Center.	1	2	3	4	5

Any comment?

Thanks for completing this survey

By: Patricia M. Hubert (2017).

APPENDIX K: PERMISSION FROM JEAN WATSON FOR TOOL

Dear Patricia. I thank you for your interest and scholarship in assessing caring.

The Caring Factor Survey is copyright owned by Springer Pub, you can find it on their website I do believe. Springer

The Watson Caritas Patient Score for self care assessment version should be on my website www.watsoncaringscience.org however, there is now a \$10.00 fee to download. Let me know if that creates a problem for you.

I appreciate you kind words and your commitment to the self-caring and compassion so needed in nursing. Please let me know if you have difficulties obtaining these materials, in loving kindness and all the best success. Jean

Jean Watson, PhD, RN, AHN-BC, FAAN
Founder/Director
Watson Caring Science Institute www.watsancaringscience.org
Boulder, Colorado 80304 USA
Distinguished Professor and Dean Emehta University of Colorado Denver,
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On May 21, 2017, at 6:51 PM, Patricia M Hubert <patricia.hubert@shu.edu> wrote:

Dr. Jean Watson,

While in the final planning stage of my scholarly project for the DNP degree at Seton Hall University I am searching for a way to measure the degree of caring, as defined in your theory. Since reading three of your books (and presently in the fourth) I've become increasingly convinced you have found the way to define and articulate what we, as nurses, actually do and should do. As a nurse of 44 years, I must say your work has resonated with me and excited me. I've selected your Human Caring Theory as the theoretical framework for my project, the aim of which is to provide more compassionate care for persons in chronic pain.

I will be working with the nursing staff of a small outpatient Pain Center in a community hospital. Phase one of my project will be working with the nurses to help them assess their own self-care and improve it so they can be in right-relationship with themselves. Once they are able to do that they should be better able to care for their patients. I also plan to assess their knowledge of your theory and then fill in any gaps to help them integrate it into their practice. So I am writing to ask your permission to use the Self-Rating Score with the nurses. I was not able to access the actual tools on your home page; I'm guessing that's because one needs permission. The other tool I was considering is the Caring Factor Survey, which I've read about; but since it is for patients I would need to reword the items to use for the nursing self-assessment. Since this is not a research study, but a quality improvement project, I have more latitude. However, a tested tool is always a better choice.

Fortunately a colleague in my cohort invited me to attend the New York State Caritas Consortium led by Donnean Davison Thrall in May. I found the group very helpful and plan to travel the 3 1/2 hours from NJ to Albany, NY for the next meeting in June. I will be implementing my project in June and July. Looking forward to your response and hopefully meeting you next year. Thanks for all you have done and continue to do for the profession.

Sincerely,
Pat Hubert

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Patricia.Hubert@shu.edu
Cell: 908-347-1776

APPENDIX L: PERMISSION FROM JEAN WATSON FOR ILLUSTRATION

Hi Pat - congrats / you have my permission -
All good wishes! Jean

Sent from my iPhone

On Sep 29, 2017, at 5:10 PM, Patricia M Hubert <patricia.hubert@shu.edu> wrote:

Hello Jean,

It's Pat from NJ contacting you again. I am finishing my manuscript for my DNP Scholarly Project and realize I need your permission to use the illustration of Dynamics of Caring Process. Figure 4. In *Nursing: The Philosophy and Science of Caring, revised* edition (2008). I plan to use in the PPT presentation and in the Appendix of the manuscript and wish to provide appropriate credit for your work. My defense date is October 16.

Thank you,
Pat Hubert

Patricia M. Hubert
Adj. Professor, College of Nursing
Seton Hall University
Cell-908-347-1776

APPENDIX M: PERMISSION FROM SPRINGER PUBLISHING

From: Patricia M Hubert <patricia.hubert@shu.edu>
Sent: Thursday, May 24, 2018 4:25 PM
To: Adam Etkin <aetkin@springerpub.com>
Subject: approval

Adam,

I am writing to confirm our conversation re: the need for approval to adapt a tool for use in my scholarly project for the DNP at Seton Hall University. The tool is the Caring Factor Survey by DiNapoli, Nelson, Turkel and Watson, which I read about in the *International Journal for Human Caring*, 2010, Vol. 14, No. 3, pp. 15-20. The title of the article is *Measuring the Caritas Processes: Caring Factor Survey*. The authors are DiNapoli et al. My need was for a tool which measures the Caritas Processes from the nurse's own perception, not the patient's, as in the Caring Factor Survey. What I did, then, was model my statements after each of the ten Caritas Processes and then reword them to become statements the nurse would use to rate the degree to which his/her own behavior reflects each Caritas. For a few statements the wording is quite different to be truer to each Caritas. You advised me that I do not need permission from the publisher since I am crediting the authors' tool by referencing them.

Please confirm my understanding of this, and that I will not need permission even if I submit to a journal for publication in the future. I appreciate your kindness.

Thank you,
Patricia M. Hubert
Patricia.hubert@shu.edu
908-347-1776

From: Adam Etkin [<mailto:aetkin@springerpub.com>]
Sent: Thursday, May 24, 2018 1:57 PM
To: Patricia M Hubert <patricia.hubert@shu.edu>
Subject: RE: approval

Patricia,

You may use the tool as described as long as you cite *Measuring the Caritas Processes: Caring Factor Survey* by DiNapoli, Nelson, Turkel and Watson, *the International Journal for Human Caring*, 2010, Vol. 14, No. 3, pp. 15-20 as the original source.

I hope this helps.

Thanks,

Adam

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